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ABSTRACT

Eight major papers from an institute on health education on drug abuse and the handicapped child are presented, some of which are followed by question-and-answer sessions. The keynote address on medical aspects of drug abuse discusses primarily the various legal drugs (and their side effects) that are used by handicapped children, usually at the instigation of the teacher. It is recommended that drug use be monitored by a physician. The second brief paper on methods and materials on drug abuse notes that the key in educational programs is in staff involvement with children. A humanistic approach to drug education is then advocated in the third paper. Two short papers focus on drug education and the handicapped child, explaining that the drug culture is open to the handicapped child as well as to the normal child and that it is natural for life to have problems. The lengthy sixth paper examines legal aspects of drugs, explains the legal process followed when an adolescent is involved in drug possession or a drug-related crime, and suggests how teachers can help students involved in the legal system. Educational aspects and ways of effectively disseminating information to teachers and children are covered in the seventh paper. Then explained in the eighth paper is a computer based resource unit in health education. (CB)

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THE UNIVERSITY OF THE STATE OF NEW YORK

THE STATE EDUCATION DEPARTMENT

DIVISION FOR HANDICAPPED CHILDREN

BUREAU FOR PHYSICALLY HANDICAPPED CHILDREN

IN COOPERATION WITH

SPECIAL UNIT ON HEALTH AND DRUG EDUCATION

A SPECIAL STUDY INSTITUTE:

HEALTH EDUCATION ON DRUG ABUSE AND THE HANDICAPPED CHILD

NOVEMBER 3, 4, 5, 1971

HOFSTRA UNIVERSITY

HEMPSTEAD, NEW YORK

PROCEEDINGS

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The University of the State of New York
THE STATE EDUCATION DEPARTMENT

DIVISION FOR HANDICAPPED CHILDREN
Mr. Raphael F. Simches - Assistant Director

BUREAU FOR PHYSICALLY HANDICAPPED CHILDREN
Dr. Richard G. Hehir - Chief

in cooperation with

SPECIAL UNIT ON HEALTH AND DRUG EDUCATION
Dr. John S. Sinacore
Special Assistant to the Commissioner

PRESENTS PROCEEDINGS OF A SPECIAL STUDY INSTITUTE:
"HEALTH EDUCATION ON DRUG ABUSE AND THE HANDICAPPED CHILD"

U.S. DEPARTMENT OF HEALTH,
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Special Studies Institute
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PROGRAM

Wednesday, November 3, 1971

8:30 a.m. Coffee and Buns — Dutch Treat

9:00 a.m. Greetings

Dr. Richard G. Hehir, Chief Bureau for Physically Handicapped Children, The State Education Department

Dr. John S. Hicks, Chairman, Department of Special Education and Rehabilitation, Hofstra University

Mr. Joseph D'Elia, Consultant, Special Unit on Health and Drug Education, The State Education Department

9:15 a.m. Pre-evaluation

9:30 a.m. Keynote Address with Reaction Panel

"The Medical Aspects of Drug Abuse"

Francis C. Bauer, M.D., Director, Center for Student Adjustment, Board of Cooperative Educational Services III, Suffolk

Reaction Panel:

Mr. Arthur R. Coccaro, Coordinator of Drug Education Massapequa Public Schools

Mr. Robert M. Erb, Associate in Education of the Handicapped, The State Education Department

Mr. Conrad G. Hecht, Director of Special Education Massapequa Public Schools

10:30 a.m. Coffee Break

10:45 a.m. Discussion Workshops

Workshop Leaders:

Mrs. Grace McCandless, Assistant Director, Bureau for Physically Handicapped Children, New York City Public Schools

Mr. Gerald E. Moore, Teacher of Children with Learning Disabilities, Massapequa Public Schools

Mr. Russell V. Riggio, Program Associate in Special Education, Nassau County Board of Cooperative Educational Services

11:30 a.m. Question and Answer Session with Dr. Bauer

12:30 p.m. Lunch

1:30 p.m. Methods and Materials on Drug Abuse

Elementary: Mr. Fred O. Gehm, Director of Special Education, Suffolk County Board of Cooperative Educational Services III

Mr. Arthur R. Coccaro, Coordinator of Drug Education, Massapequa Public Schools

Secondary: Mr. Stanley M. Lewis, Teacher of Health and Physical Education, Human Resources School, Albertson, New York

Mrs. Glorya Selton, Director of Health Education, Central High School, District 3, Merrick, New York

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Thursday, November 4, 1971

8:30 a.m. Coffee and Buns — Dutch Treat

9:00 a.m. Keynote Address with Reaction Panel

"The Legal Aspects of Drug Abuse"

Mr. Mark Groothuis, Attorney at Law, Criminal Division, Nassau County Legal Aid Society

10:30 a.m. Coffee Break

11:00 a.m. Discussion Workshops

12:30 p.m. Lunch

2:00 p.m. Question and Answer Session with Mr. Groothuis

3:00 p.m. Book and Materials Fair

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Friday, November 5, 1971

8:30 a.m. Coffee and Buns — Dutch Treat

9:00 a.m. Keynote Address with Reaction Panel

"Educational Aspects and Ways of Effectively Disseminating Information to Teachers and Children"

Dr. John S. Sinacore, Special Assistant to the Commissioner

10:00 a.m. Coffee Break

10:30 a.m. Discussion Workshops

11:15 a.m. Question and Answer Session with Dr. Sinacore

12:30 p.m. Lunch

2:00 p.m. "Computer Based Resource Units in Health Education"

Miss Sarah Dunn, Project Coordinator, Special Unit on Health and Drug Education

4:00 p.m. Post-evaluation

GREETINGS

Mr. Conrad G. Hecht - Institute Director

Good morning and welcome to a Special Study Institute: Health Education on Drug Abuse and the Handicapped Child.

The State Education Department, Division for Handicapped Children, Bureau for Physically Handicapped Children is sponsoring this Institute in cooperation with the Special Unit on Health and Drug Education.

I believe that this meeting is the first of its kind to be held in New York, consequently, the entire state is watching what is done here. The drug problem has been said to have reached epidemic proportions among our school age children, and as educators, we must be equipped to prevent, battle and extinguish this menace to our youth.

Our handicapped population may be particularly susceptible to the problems of drug abuse and addiction. Many of them are legally and medically on dangerous, addictive kinds of medication to control seizure disorders and/or to achieve behavior modification. Many of them have poor judgement as an offshoot of their handicapping condition and are therefore more prone to try a dangerous drug "on a dare."

It is only by working together that we can hope to combat this problem.

We have a group of specialists who are experts in their respective fields to share their expertise with you. I hope you find this Institute a meaningful and rewarding experience.

GREETINGS

Mr. Robert M. Erb:

It is a happy occasion for me to be privileged to bring you greetings from the Bureau for Physically Handicapped Children. As you can see from the program, I am pinch-hitting for my chief, Dr. Richard Hehir, who regrets that he is unable to be here due to a three-week battle with pneumonia. I am happy to report that he is winning that battle. Therefore, I am a substitute at this Institute while my boss is destitute because he cannot be here.

During recent years the problem of drug abuse has grown to alarming proportions. Many of our handicapped children - of necessity - use prescribed drugs and are, therefore, faced with the danger of addiction. It is easy to see that they could be victimized by other students to become not only illegal users but pushers as well. I have been told of instances of defenseless crippled children in schools having drugs forced upon them.

Every effort needs to be made and every available aid should be given to those involved in the field of educating the handicapped to combat this fast growing menace to our special children. These children must be given all the appropriate direction and counsel that can be given them concerning the dangers and consequences of drug abuse.

The purpose of bringing together for this three-day session this fine group of dedicated people is that you might, as teachers and administrators, further acquaint yourselves with the techniques of developing programs and curriculum for handicapped children receiving health education with special focus on combating drug abuse among handicapped children.

I am indeed pleased with the selection of specialists who will be addressing and working with you for the next few days. I am delighted with the quality of those who have consented to make what I believe will be a most worthwhile contribution in combating this acute problem.

The planning committee was concerned that this program should be an important

and professionally stimulating experience for each of you. The variety of the experience should be continually challenging and rewarding as well as exciting and enjoyable to you.

I would like to pay special tribute to Mr. Conrad Hecht, our Institute Director, who has worked very hard to put together this worthwhile project.

Each of us should go away from here with new ideas, plans and expertise with which to attack the problem before us.

I appreciate your interest and attendance at this Institute and I hope that this conference will be as gratifying to you as it is for me to have greeted you this morning.

GREETINGS

Dr. John S. Hicks:

On behalf of Hofstra University, I would like to welcome you to the Conference on Drug Abuse with the Handicapped. The Department of Special Education and Rehabilitation is very pleased to cooperate with the Special Unit on Health and Drug Education of the New York State Department of Education and is more than happy to serve as the host to this three-day conference. I bring you greetings from the University and wish you the best of success in this three-day institute.

As a university program dealing with the training of teachers of handicapped children, we are very aware of the problem of drug abuse with the handicapped child. Furthermore, it appears more and more critical that our teachers have accurate information on how to deal with this problem of drug abuse in school children. It is impossible to ignore. It is critical that teacher training institutions pay very close attention to this problem. It is one of our greatest responsibilities at this time to provide our teachers with the kind of information which will be given to you in this institute, so that they may be better equipped to handle drug problems as they go out to teach in the special programs in this area.

There was a time, in the not too distant past, when it seemed that the special teacher really did not need to concern himself or herself with the problem of drug abuse. It appeared that the retarded child or the physically handicapped child or even the disturbed child was somewhat exempt from the drug problem. That is not the case today. The influx of drugs and drug abuse in public schools throughout the nation and throughout the Long Island area has become so extensive that we have to be ready to handle this problem and handle this problem effectively. It is a cross cultural problem. It does not deal with affluent school districts or deprived school districts or only middle-class school districts. The problem of drug abuse is met in almost every school

district on the Island today. At the same time, more and more, the problem is creeping into the lives of the handicapped student. It has become, in some instances, as critical a problem in the rehabilitation of handicapped children, as is their own disability.

It is becoming apparent that teachers, as are many parents and other well-meaning and well-trained people, are not adequately trained to handle many aspects of drug abuse. Teachers are not familiar with the signs of drug abuse. Teachers are not aware of the consequences of drug abuse. Teachers are morally indignant about the possibility of drug abuse with children. Day by day the sensitivities of teachers and the awareness of teachers of handicapped children are being more and more brought to bear on this tremendous difficult problem in our educational system.

I welcome the chance, as do most of my colleagues, to discuss this problem openly at a university setting. I welcome the chance to sit down with professionals working in the field and think about and learn more extensively about some of the aspects of this particular problem. I am sure that those of you in the audience who happen to be our graduate students who are participating, as well as those of you who are teachers now functioning in the field or other professionally trained people functioning in the field, will come away from the conference with more information, more knowledge, perhaps some changes in attitudes, and that through your experiences at this institute you will be better trained to deal with this most pressing problem in the schools today.

Again, I welcome you and would like to suggest that you make yourselves at home at the university and please let me know if we, as a department or as a university, can help you any further in this area.

GREETINGS

Mr. Joseph D'Elia:

Dr. John Sinacore, who was my boss up until the end of August of this year, asked me to pinch hit for him this morning, as he is unable to get here, and provide a type greeting he feels you are all entitled to from the State Education Department.

Some of the things John asked me to convey to you are in the area of communications. His concerns are the methods that one uses in his classroom in terms of the whole area concerning drug abuse, methods of teaching. He hopes that at the end of this conference many of you will see things perhaps a little differently in terms of what you have been doing and what you have seen being done in your classrooms.

He emphazises one major point. We have to get kids involved when we talk about they themselves making decisions regarding the use of drugs. We have to discard the old traditional methods of communicating with youngsters. We cannot use the traditional methods anymore. The problem is growing fast and furiously around this state, the country and the world itself.

Another particular point I was asked to deliver to you is that the Unit on Health and Drug Education stands ready to assist in all school districts in this state. They are interested in doing things for you in terms of teacher training.

Dr. Sinacore also suggests that perhaps you might want to consider quite seriously the computer based resource units that you will have presented on Friday. They are very valuable.

Once again, thank you for attending. Dr. Sinacore and his staff, in the State Education Department, stand ready to assist you in any way they can.

KEYNOTE ADDRESSES WITH REACTION PANELS

Dr. Francis C. Bauer - "The Medical Aspects of Drug Abuse"

It is extremely difficult to put into a talk what is known about drug abuse without getting into all sorts of horror stories, getting very dramatic and very alarmed. It is extremely difficult on the other hand to underplay or underevaluate the seriousness of our present situation. Your planning committee very obligingly furnished me with some of the questions which they thought most appropriate to cover, in an overview, at the opening of this conference. Interestingly enough, the title of that address was "The Medical Aspects of Drug Abuse", which prompts me to immediately begin with an apology because the medical profession has been very much involved in drug abuse albeit inadvertently since the beginning of time. It isn't necessary to go back to ancient civilization for I'm sure you all know that in the early days of medicine the priest physician had very little at his disposal except very potent drugs with which he treated a variety of illnesses. Anything which was not surgical in nature, anything that could not be dealt with by means of the knife, was handled by having patients admitted to the temples where they took what amounted to a prolonged sleep therapy. The drug employed at that time was opium. Various derivitives of opium, some of which are lost to antiquities, have followed us to the present day. Probably the earliest recorded addiction forced on people by the medical profession goes back to the Greek and Roman civilization. That, of course, points up the problem essentially with the use of drugs which affect the central nervous system. Opium and its other derivitives, morphine and codein, and others produced such a remarkable state of euphoria that people forgot what was bothering them originally. If you can keep them pleasantly stoned for four to six weeks, they are very likely to have allowed nature to cure whatever other ailments they have had. The euphoria itself was a big factor in

Dr. Francis C. Bauer - continued

public relations. Treatment became extremely popular.

The drugs of abusion are those limited to drugs that have a specific effect on the central nervous system. We do not tend to abuse other drugs but those that affect the central nervous system can do one of two things. They can either depress the central nervous system or they can stimulate it. The youth culture of today, of course, has managed to combine the depressants and the stimulants into very exotic combinations which produce reactions that have not been anticipated. The fact is that drugs or substances in nature affect the central nervous system and accordingly change the mood of the individual. When one recognizes that every civilization always had to find some substance and distill it or ferment it or extract it from the leaves of trees or plants, every civilization has had to produce something which, when taken internally, would affect the central nervous system and this drug, or this alcohol, this primitive potion, which was part of every civilization, was always used on ceremonial occasions. It occurs to me that if man was as social as he is supposed to be, it is quite remarkable that he has always had to find something to distort reality when a whole group of people had to get together. Even religious ceremonies are signified by the presence of some kind of mood and stimulating substance, some kind of drug or an alcohol, and alcohol is a drug which will tend to depress the central nervous system and to facilitate the process of distorting reality and relax the built-in inhibitions so that the human organisms can function without anxiety. Until the early 1900's, there were no drugs worth abusing except those which were found in nature; opium and morphine derivitives. But with the advent of the drug industry, with the commercialization of medications superimposed upon man's innate capacity to improve on nature, we began synthetically to produce a number of substances far more potent than those found in nature and the variety of drugs now available change the

mood to elevate or depress the central nervous system. This number is quite enormous.

There is nothing new about the abuse of drugs except the fact that drugs today are being abused to a much greater extent than has ever been known before. The extensive drug abuse is certainly without precedent and the models which we use in an attempt to understand the situation are no longer applicable. As has been suggested by Mr. D'Elia, the things which we have been doing don't seem to work anymore because the rules of the game have changed considerably. Certainly ten or fifteen years ago if a youngster was sent to me for a referral, and I'm a psychiatrist by training, and part of the presenting complaint was that the child was using dangerous drugs or abusing them, there would have been no doubt in my mind, that this was a youngster who had deep-seated emotional problems of some kind or another and that the use of drugs or the abuse of same were symptoms of the deep-seated emotional disturbance. It is no longer reasonable to react this way because the majority of young people who are abusing drugs in our society is tremendous and of those who are abusing drugs the majority are otherwise psychologically healthy individuals. Psychological tests reveal no basic personality disturbance in a significant number of cases. We can no longer suggest this is merely a clearly identifiable illness that will respond to treatment according to the medical model. This is important to know because it is much easier to pretend that all of these kids are very sick and that means that in communities we should open a clinic and we should staff this with a man in a white coat. Then all we have to do is identify the drug abuser and send him to that clinic and he'll walk in the front door and have four visits and something mysterious will happen and he will come out the back door cured of his abuse problem. The community will expect that the child will have also cut his hair and discard the outlandish clothes that are the discussion of much of the parental disturbance.

The fact of the matter is, if this is to be classified as a sickness at all, it is certainly a very different kind of illness from anything we have ever known, and it requires a concerted effort to discover new means of curing it.

Inadvertently, medicine has become involved with this because, traditionally, people go to doctors only when they think they are going to die, which is why the calls usually come in after eleven o'clock at night. You can put off your aches and pains during most of the day when you are easily distracted, but when you are alone, in that moment, half awake and half asleep, and not quite either, the insecurities surmount to the point, unconsciously, where people feel they are going to die and they call for a physician. Traditionally, when people go to a physician they expect to be treated with or to some bottle of goodies that will make all of those ills magically disappear. In spite of the fact that thirty percent of all illnesses in the United States are psychosomatic in nature, people continue to be treated largely with chemicals of some type or another. In the old days, when physicians didn't know what else to do with a patient who demanded some kind of treatment, he was able to give him a placebo or at the very worst prescribe some kind of vitamin and so the problem didn't become so very apparent. Vitamins don't give you so much in the way of kicks. Nobody ever got high on Vitamin A, B, or C. They're not much fun, they don't even taste good. But the fact was many, many people were consuming vitamins and other medications which had no known value and simply were getting into the habit of taking something when they felt bad. Since these substances did not have addictive properties there was no problem, but when the day came that instead of giving out vitamin tablets physicians began permissively to prescribe Miltown, Valium and Librium, and a host of other tranquilizers, then like it or not we did become involved in creating an atmosphere or climate in which drug abuse could flourish. Contrary to common opinion, most people are not

turned on by some dirty old man in a red coat who hangs around the school-yard who says, "Hey kid, you want something good?" Most young people are turned on the first time with substances which come from their handy medicine cabinet which is usually well-stocked by the parent. Medicine alone is not the only profession involved in creating a climate in which drug abuse can flourish. Some years back, for some interesting reason that will probably never become apparent and certainly never be understood, it was decided in the United States of America that unhappiness of any kind was a symptom of emotional disturbance. When we made unhappiness a symptom and began to deal with it on again a basis of a medical model, the stage was set for another widespread infiltration of harmful substances. Anybody who was unhappy for any reason whatsoever, rushed off to some kind of therapist, some kind of a counselor, who discovered that the process of psychotherapy could be accelerated tremendously with the use of chemicals. Beyond the realm of medicine it did not take long before commercial interest rapidly infiltrated this field and you've got the wholesale commercialization of potentially dangerous substances in common use. Indeed, you have a barrage of advertising, a little campaign through television and radio commercials and billboards on the highway that, at no time, should anyone feel any discomfort. We created the notion that there is a bottle someplace on somebody's shelf. We got a whole flock of non-prescriptive drugs that came readily available and you know what these are: the Sleep-eze and the No-Doz and the Compoz and the Vivarin. All of these are available without prescription and all of these are advertised as spot commercials in between your evening's entertainment to the point that, subliminally without being aware of it, we become brainwashed to believe that discomfort cannot be tolerated and immediately you must reach for one of these wonder substances that will make everything alright for the future. Perhaps the most asinine and absurd of all of these promotional

campaigns was the one fostered by the Bayer Aspirin Company. You may well have seen that commercial where they advocate, in a real hard sell, that at ten-thirty in the morning the housewife should take a Bayer break. Not a coffee break, a Bayer break, for no reason at all for at ten-thirty she should stop whatever she is doing and take two Bayer aspirin. Now, I have not been made aware of any surveys as a result of this kind of publicity but on the basis of what has been done before, there is a tremendous number of housewives in this country who are stopping at ten-thirty for two aspirins simply because the idea has been planted in their mind. With all of this background, we certainly recognize that the kids in whom we are most interested in at this conference and in your daily work are kids who have even less resistance to the climate of the day, kids who have less independence regarding their actions and kids who are more susceptible and more gullible to the attractions held out to them by people already using. The possibility of the handicapped child, be it a physical handicap, emotional handicap or mental retardation, the possibility of his being involved in the drug scene constitutes a special danger.

Again, there is an aspect of this which is extremely important and frequently overlooked. Drugs have become intimately involved with our school program. Not a year goes by that I don't have at least one-hundred requests on the part of parents who are sent for consultation, to explore the advice of the teacher who told the parent to take the kid to the doctor and get him on some kind of drugs. Parents are frequently told by teachers that "if he were tranquilized, he would pay more attention and he would get higher grades". Other parents are told "if this kid doesn't slow down we'll put him out of school and you'd better take him to your pediatrician and get something to calm him down because he is disruptive." I have other parents who call without the advice of teachers requesting some kind of medication that will get Mary through the concert on Friday night or will get

Johnny through the debate. Here again we have a very difficult situation with which to deal, because none of these substances should be used permissively. It would be a conservative estimate based on my own experience that more than fifty percent of all school aged children who are using drugs by prescription do not really need to be taking those drugs. This is part of the climate and this is part of the situation. I'm not talking about aspirin for headaches, I'm talking about kids taking benzedrine during the elementary grades in school, I'm talking about kids taking librium and vallium, and mellaril. I'm talking about the ads that appear in medical journals in which you see a kid tearing a school room apart on one page. On the other page facing it you see the same child sitting angelically in his seat, absorbing every word the teacher is giving out and on the bottom of the page it simply says mellaril five mgs. three times a day. The tendency is not to use this for the extremely disturbed child, who really requires it, but to use if for the other child because if its good for one it would be twice as good for the other one who's got a better head start not being handicapped. In any event I think you know what I'm saying. The problem of drug abuse is one that involves not only medicine, not only education, not only the family, not only other institutions of our society, it involves our entire society. The question was asked what are the dangers of handicapped children who must necessarily take drugs. I'm talking now about the authentic cases who require medication on a regular basis. What are the probabilities of addiction developing in such youngsters? Fortunately enough this probability is quite low. Most of the substances are prescribed for handicapped children and which are necessary on a regular basis, perhaps for an entire lifetime, are substances which have very low addictive potential. Perhaps it might be best to list these kids, who are classified handicapped youngsters and who require daily medication, in one or two categories. The one is the category

Dr. Francis C. Bauer - continued

of brain damage, associated with a convulsive disorder which requires a medication that would be called an anti-convulsive - a drug which needs to be taken every day, usually three times a day, in order to forestall the possibility of the child having a grand-mal seizure, an epileptic fit in ordinary language, or a petit-mal seizure, or some other form of epileptic manifestation. The current edition of the Physician's Desk Reference lists twenty-two separate anti-convulsion medications which are currently on the market. Of these the most popular are, of course, Celontin, Mesantoin, a drug called Mysoline and one called Tridione. These are all commercial names. None of these drugs has an addiction liability or potential, which means if the child is suddenly withdrawn from this medication he will not show symptoms of withdrawal. This, by definition, is what addiction means. If the medication is suddenly withdrawn he may indeed begin to have convulsions because his disorder is now out of control, but this is not the result of the drug. So that all of these anti-convulsive medications can be used under medical supervision by prescription without any danger of creating an addiction potential and because a kid perhaps all through childhood in his formative years takes Celontin three times a day does not mean that he is more susceptible to use of other drugs when he gets into Jr. High School or the High School level. Because this kind of medication which is required is generally provided in such a setting that the child incorporates it into his daily life, he develops insight usually into his condition and the nature of it, this is not a potential problem. All of these drugs, however, are capable of producing what is called tolerance, which means that over a period of time, the child becomes accustomed to taking anti-convulsive medication and larger doses are required to maintain the desired effect. Frequently, especially in the course of treating youngsters with epilepsy, there is required a change of medication. After three or four years on Celontin it may be necessary to switch him over to some other preparation because of the tolerance that has developed.

Dr. Francis C. Bauer - continued

There is one dangerous drug, however, extremely dangerous, that is used widely in the treatment of convulsive disorders and this is Phenobarbital. Phenobarbital is a barbiturate, a down, a central nervous depressant. While phenobarbital does not produce addiction which is a physical dependence on the drug, it does indeed create a psychological dependence. The principal use of all anti-convulsives is to avoid convulsions, but each drug has side effects. Now, Dilantin and the others I mentioned have no psychological side effects. You don't get high on Dilantin. The side effects are all physiological and they may be unpleasant, but there is no immediate danger of psychological dependence because the drug doesn't make you feel better or make you feel any different. You don't get high on it. Phenobarbital has a side effect of drowsiness which permits escape into a pleasant euphoria. So, it is possible in the use of Phenobarbital legitimately prescribed for the management of a convulsive disorder to inadvertently create a psychological dependence on the drug. Being aware of this, the parents and the physician certainly become involved in working with this child to recognize the dangers involved and to minimize the psychological escapes which the drug makes possible.

There's a second group of drugs in common use which has nothing to do with convulsions and these are drugs called ataraxic. In other words, these are the tranquilizers. Of these drugs there are currently sixty-four in common use. This was as of Monday afternoon. I don't know what happened yesterday because they appear on the market in different trade names with remarkable rapidity. Day after day new ones are invented. The technical names of these drugs are not really that important but they fall into three categories, one of which is the hydroxylamine chemical compound which tends to produce tranquilization - it slows people down. A side effect is drowsiness, and high dosages will induce sleep. Certainly for the child who is hyperactive and extremely distractible. Atarax (which is a trade name) comes in pill form and syrup form, a very sweet, nice tasting kind of

thing. Atarax will certainly slow a kid down. It will make him less distractible. It may indeed open him up and make him accessible to the educational process. Again, unless there is no other way to control this child's behavior, I would be extremely reluctant to prescribe this kind of medication.

There is another interesting feature, by the way, of people who get central nervous system drugs in their possession. In twenty years of being a physician I have never met a single patient who had his appendix out and then operated on his next-door neighbor by virtue of that experience. On the other hand, I have hardly ever met a patient who did not get a prescription for Thorazine who within a week had not spread this all over the neighborhood. And we have local unlicensed pharmacies on every street. Somebody on the block is going to a shrink and is coming back with a bottle of pills and says this is something really wonderful and everytime one of the neighbors is in a snit over one of the kids or this or that, he says "Just wait, I got something good for that. Let me give you some." Thorazine is extremely popular. So is Compazine. These are drugs which again do not addict the individual. They do not cause a physical dependence so that when the drug is withdrawn you would have terrible symptoms. But these are drugs which produce tranquilization of the mood - a nice quiet feeling in spite of all kinds of anxieties. I would have loved to have had one of these things on Hempstead Turnpike about two or three hours ago. Sitting in this traffic jam and seeing the buildings and knowing I should be there and could do nothing about it stimulated considerable anxiety. Had I been able to pop a Floradine, I probably would have said, "Isn't this interesting. Who the hell cares if I get there or not." If you're going to make a choice between those two feelings there is no reasonable difficulty in predicting what that choice will be. So that the psychological hazard of habituation or becoming used to a substance such as this - psychologically that hazard is quite real and it should not be given to children unless there has been a complete workup on the part

Dr. Francis C. Bauer - continued

of the entire health and pupil personnel service. There should be psychological tests. There should be medical evaluations. There should be teacher evaluations before a determination is made that this is important enough to put a child on drugs. A third category is known in trade names as Depros. Miltoun (the most commonly used) and Librium are in common use. These drugs, too, ameliorate the mood. They tranquilize people, they eradicate tension and they also tend to promote unconscious fantasies - a feeling of relaxation. Now, it is possible that to induce such a state would enable someone to harness this child's energy for the moment. But in regard to the long haul as to the possibility of habilitating him to begin with or getting him into that frame of mind that whenever anything important comes up he's got to be fortified with something out of a bottle, this is an undesirable lesson to be teaching by example. So this is not the business of kids using drugs legitimately. It is not something which should be dismissed lightly. It is something which is extremely important. I would encourage consultation on the part of school people with local pediatricians, because pediatricians themselves need to have some understandings of what the problems of the classroom are and may be able to work with the health team to determine how things could be worked out in that classroom without the extreme measure of employing drugs. So, as a general rule, it would be my very firm principle, except for anti-convulsives over which we have no choice, that all other drugs be given to children who need them only as a last resort.

Now, there is an interesting phenomenon that occurs with young children, especially under the age of ten, and that is that certain drugs have paradoxical effects. A barbiturate, for example, usually will depress an adult if he takes it - it depresses his nervous system - but barbiturates frequently stimulate young children. On the other hand, the amphetamines, dexedrine and benzedrine, which are forms of speed, stimulate the central nervous system of adults and cause extreme euphoria

Dr. Francis C. Bauer - continued

and excitement, but they have the paradoxical effect of depressing young children. So that especially in that remarkably vague syndrome known as minimal cerebral dysfunction - which is only one of fifteen names by which this goes - especially in this syndrome we find quite a large number of youngsters who are taking amphetamines. Benzedrine, dexedrine or some combination thereof used to slow the kid down. The brain injured child, by definition, is hyperkinetic, hyperactive, distractible and dexedrine is used. Again, I'm not denying that there may be specific indications for using this medication. But they are not nearly as common as one would believe. They should be used with care only after complete studies and only after all other resources have been exhausted.

Of all of the drugs I've spoken about this morning, the most dangerous that the kids come in contact with by virtue of being handicapped sometimes, is this group of amphetamines, the speed. Because stimulants, of themselves, have an action on the central nervous system in the form of destroying tissues, tolerance builds up rapidly, a larger dosage is needed to get the desired effect and long-term use of large doses of amphetamines cause a kind of brain damage which is irreversible. It also produces a kind of excitement and a kind of feeling, psychologically, which is almost irresistible and as youngsters progress from the use of amphetamines to quiet them down in the primary grades into the Junior High School where they begin now to get different effects from the drug and where the drug may be more readily available, then most certainly we have contributed to the potential danger of a kid abusing this particular substance. So then, this one must be looked at with extreme caution and a great deal of care.

The question was also raised and I think it important to touch on this, as to how the school relates to the community and to the parent. I have already suggested that pediatricians be involved. Any child who is handicapped, who is in a program, who is required to use drugs - in every single case there should be

a direct contact between the teacher and the parent. If the drug is to be used during school hours it should be mandatory that the prescribing physician send a letter to the school on his stationery, over his signature, giving the name of the drug, the duration of time that he wants the child to take it and specific instructions for the number of times a day that the child should take it. The parent should bring the medication to the school in a sealed container and personally deliver this either to the school health personnel or to the building principal. It is necessary to become this elementary. In one program in which I was associated, for profoundly retarded children, there was a youngster who, in addition to his profound retardation, suffered from a convulsive disorder. Accordingly, he had to take Dilantin three times a day and the middle dose had to be given in school. The teacher thought it would be a very good idea to allow this child to bring the medication from home himself and to keep it in a drawer which was not locked or otherwise secured and to medicate himself because it increased his feelings of independence. It enhanced his ego and it also helped him to count a little bit. I suggest that this kind of education is better performed with some inner substance and not with a potentially dangerous drug. This kid would have been a pushover for anyone else on the school bus who may have wanted to confiscate that material and use it for other purposes. He would have been a pushover for over dosage because he was not that bright, which is why he was in that program. And these things do happen. Especially today the security of any drug which is necessary must be safeguarded and it should be delivered by the parent and it should be kept in a locked container in the school and no one but the school nurse or someone designated by the medical team, in an emergency, should administer that substance. It should not be re-ordered and regiven repeatedly. At least once a month, except in a case of epilepsy, there should be another up-dated letter from the physician indicating that he still wanted the

patient to use this drug. This is important because some of these substances are renewable ad lib and on the basis of one prescription for the oldest child in the family and mother gets it in rather large supply and after it's no longer necessary she stops giving it to that kid but three years later the second child comes along and enters the school system. There's a complaint from the teacher about one thing or another and mama remembers that it's in the cabinet and she may prescribe it by herself. The physician may want the child to have the medication for two or three weeks but then mother feels she's afraid to take the child off medication so, at the end of that three week period, she evaluates his behavior and sometimes continues the medication far beyond the desirable time and for this reason, an up-dated request on the part of the physician to provide this medication ought to be available at the school system.

Again, possibly in the question period, there will be a chance to allude to some of these other suggestions which were made. The role of the school psychologist, how to detect the effects of drugs, etc.

I have said absolutely nothing about illegal drugs today in regard to our Special Education kids. I would hope you would recognize that we have a big enough problem with the legal drugs that come into the hands of these kids and the conditioning process in which we participate.

Now, possibly in your workshops and possibly in the later question period this morning there will be an opportunity to respond to specific questions about the illegal substances which are available and which are causing difficulty.

You can always shake up a P.T.A. meeting when you go and talk about drugs and the parents are all willing to blame anybody, except themselves. They are all willing to say it's the school's problem that kids are using drugs. And you can always shake up the meeting by asking, "When do you think that kids first begin to use hard narcotics?" Some of the more daring people who have been reading

newspapers say, "Oh maybe thirteen years of age," and you say no. "Oh maybe eight or nine," and you say no. You suggest to them that most children in our society are introduced to hard narcotics at six months of age. This is the time when the kid gets teeth and he is very irritable and it annoys the parents more than it does the kid. So they run up to the drug store and get a bottle of Paragoric and they rub it on the child's gums and it itches and it tingles and it feels very pleasant and it also sends him off to cloud nine, which is a desirable effect on the part of the parents. Paragoric is a morphine derivative.

Thank you very much.

Reaction Panel

"The Medical Aspects of Drug Abuse"

Dr. Francis C. Bauer

Mr. Arthur R. Coccaro

One of the first things that was mentioned was the fact that we are involved with suggested drugs that relieve pain and I think this is a vitally important aspect that we realize that often times, in the educational setting, we are dealing with people who are involved with a drug for a specific reason because they are in a painful situation and the best way to relieve the painful situation is to get involved in a pain relieving drug. And also involved in this is a mood change and the drug is being used for a particular reason. I think many, many educators and many people in the allied fields do not realize that we are dealing with a person who is involved in a mentally painful situation. Here again, Dr. Bauer alluded to the fact that we are social animals and the lack of understanding of social interaction, the lack of understanding of how to react to other people, for many people causes pain and causes a mentally painful state and the implications for drug abuse that is going to relieve that pain are very real and very important aspects to think about.

Often times, in education, we do not like to deal with the pathology of emotional problems but I feel that in relating to Dr. Bauer's statement that we are going to have a low level, we are going to deal with low level emotional problems. I think this is probably a realm that we should start considering and thinking about and this is one of the things in direct relationship to what was said that health education must do. We must get off the cognitive and start dealing at the affective level with these types of things. If your son or daughter had a mild scratch or had something you could deal with at the first aid level, you'd deal with it. What makes us think that basic emotions are something that we have no right to deal with. It's just like arms and legs. We deal with them every day. Everytime

you deal with your kids in a classroom situation you're dealing with their feelings and we've got to get down to that level. We've been scared away by this type of thing for a long time. Like the psychologist's and the psychiatrist's roles, we do have a role in dealing with people's feelings and that is the developmental sequential thing we've been leaving out in education and we'd better get to it because all the other programs and all the other garbage about dealing with drugs, talking about drugs on the cognitive level is easy - it's an easy thing to do but it does nothing. It really is a fantastic waste of time, waste of effort and waste of money.

In a health education program, I think we must deal with the self-awareness about the home and as Dr. Bauer suggested, the first pushers that a child comes in contact with are probably his parents. We must deal with the three things - awareness, mastery and social interaction and awareness is the awareness of your chemically surrounded environment. You must start talking about the potential dangers and awareness at home. All we really do is take a kid and, as Dr. Bauer suggested, we build him up on a ladder of drug abuse. For thirteen years he sees his parents, his mother and father, get involved in the drug situation and it's a ladder of drug abuse, so when a kid turns to drugs when he's involved in a painful situation, we ask shy and how come. Because it's been around him - it's been his environment for thirteen years or even before and if we deal with a handicapped child, these three things - this aspect of self-awareness, of body awareness of what you've been given to deal with - the respect for what you have, respect for the mastery that you have and the understanding of social interaction, especially for handicapped children, is vitally important. My last thought is that we must again, in relation to Dr. Bauer, (I'm projecting on an educational level), we must combat the media as a total effort. We must combat the media because if we don't all the great drug programs, all the special institutes, we workshop the situation to death but we've never had the guts to start really talking about where it's all at. It's in the media. The fact is that seventy-two percent of the commercials on television deal with the concept that you've got to be up.

Mr. Conrad G. Hecht

I think that educators have a tendency to talk about the good that television can do, particularly in verbal skills. We point to shows like "Sesame Street" being incorporated into our classrooms on many occasions and I think maybe it's time for educators to start to advise parents of some of the dangers, as Art Coccaro and Dr. Bauer pointed out, that are inherent in unsupervised TV watching.

I'm happy that Dr. Bauer qualified his remark about promiscuous use of drugs because there are many children in school today who wouldn't be there, because of severe behavioral disorders, were it not for some of the drugs that are being used. I would hope that the teacher would not prescribe the drug for a behaviorally disordered kid but rather refer the parent to see her physician. Again you're getting a team approach on the problems of the child. Talk to your family doctor about the problem that your child is having in school and see what he says. Certainly, check it out. Find out that it's not a physical problem, etc. I would hope that there is no educator going who would suggest the out and out use of any drug. Carrying what Dr. Bauer said just one step further; he spoke about the need for the teacher and the parent to be in close communication when a youngster is using a drug. It's been our experience, I suspect particularly in special education, we know that very often parents are not very accurate reporters and I would hope that some kind of release could be worked out so that the teacher who can perhaps deal with this youngster a little more objectively, would be able to communicate directly with the physician and talk about the kinds of behavior that are going on in the classroom. Things, that maybe the mother either cannot or will not transmit to the physician.

Incidentally, too, along the lines of what Dr. Bauer said, state law prohibits a nurse, or a teacher or anyone else from giving a child a drug of any kind, including an aspirin, unless she has written notification from the physician. If this practice is not being done in your district, it's clearly in violation of the law.

QUESTION AND ANSWER SESSION

"The Medical Aspects of Drug Abuse"

Francis C. Bauer, M.D. - Director, Center for Student Adjustment, Board of Cooperative Educational Services III, Suffolk

Question - Under what circumstances would a person use drugs?

Answer - It would certainly be valid and reasonable for a person to use drugs if he has an illness which requires the drugs. I can think of no other circumstances, except one. There is a group of American Indians who had used peyote and mescaline and some of the psychadelics for as long as their history has been recorded. They use these in their ritual services of certain religious concepts which they have and when the drug laws were passed in this country outlawing the use of drugs, these Indians incorporated into a church - I think it was the North American Church - I've forgotten the exact title of it - and they were given exception from the law and were permitted to use these substances in religious observances. Now, it should be noted in that connection that this group uses the drug, the peyote which comes from the mushroom, they use this drug only during religious experiences and there is no history of abuse in this connection. I can't think of any other situations outside of a diagnosed illness where it would be reasonable for a group to use drugs.

Question - Would this include psychological illnesses?

Answer - The answer would be yes. There are certain anxiety states and other psychiatric entities where the therapy is facilitated through the use of drugs but this then is always done by prescription and should be done by a responsible person. But the widespread use of these substances without accurate diagnosis is regrettable and dangerous.

Question - Is phenobarbital an addictive drug?

Answer - I put phenobarbital in a class of drugs which is a non-addictive class. The reason for that is the technical definition of addiction. Addiction is defined

as a psychological and a physical dependence on a drug so that when the drug is withdrawn, it creates a diagnosable set of symptoms called the withdrawal syndrome in which there are muscle cramps and diarrhea, nausea, vomitting, the nose runs, the eyes tear, the temperature control is lost and the patient shivers. This will go on for a period of about 72 hours. Now, any drug which produces this reaction on withdrawal is referred to as an addictive substance. Any drug which does not fit that definition, technically, is not classified in that group. Barbiturates and amphetamines are much more dangerous although they don't produce this symptom and are technically not addicting. They are much more dangerous when you start to taper off after prolonged use because they can result in sudden death, convulsions and other symptoms.

Question - Would you agree that kids who try drugs and then get hooked are really trying to alleviate some deep-seated depression?

Answer - To begin with, it's important to recognize that there are only certain drugs on which you get hooked. Hooked really means to be addicted and this is the property only of narcotic drugs - opium and all its derivatives - that's opium, morphine, heroin, codeine, paragoric and, I think, ipicac. These are drugs which have addiction liabilities and once you are using those drugs regularly, the physiology of the body changes in such a way that the cells of the body literally cry out for this substance. They can't function in the absence of heroin and, accordingly, when the heroin leaves the body, there's a physical reaction causing the individual to go back and take another dose of the drug. That's being hooked. Now, the motivation for using drugs which may ultimately lead to heroin addiction, those motivations are extremely varied. I would say that there must be a significant number of kids who may be basically depressed or anxious and who find the drug experience such a pleasant relief that the underlying depression and the good feeling from taking the drug is a motivating factor in the continuation of drug use. But I

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would want to stress again the importance of understanding that if you take all of the young people who are using drugs and include in that category marijuana and the psychadelic drugs on which you do not get hooked, by the way, - if you include those, then the majority of the kids who are using them are not using them because of depression or anxiety. They're using them, first of all, because they're available. Secondly, because it's become identified with the youth culture. Thirdly, because it provides a ready outlet to rebel against authority which is characteristic of adolescence and fourthly and fifthly and sixthly, a number of other reasons which may not be psychiatric at all. So, certainly, there are some who would fit your description of being basically depressed but this would not be the common pattern in the overall picture.

Question - How many times does a person have to use a specific drug in order to become hooked?

Answer - This again is extremely variable. Contrary to common opinion, you do not become hooked, even with heroin, on the first shot. Regrettably, people have used heroin in moderate dosage - skin popping, that is using it under the skin, not taking it intravenously - for a considerable period of time without developing physical addiction. Generally speaking, it will take anywhere from a month to six weeks to produce a genuine addiction - that is, the physical dependence that would cause withdrawal symptoms. But this is also related to the strength of the drug being taken. Again with heroin, pure heroin is extremely hard to come by, although it's getting easier since it's coming in from the Middle East. They haven't learned to cheat yet and they deliver a product and charge for it and it's genuine and people who aren't used to that, take an overdose. Traditionally, heroin is cut at every stage of the way. It's delivered pure from the laboratory and then the big syndicate dealers cut it at least in half and then it goes out and gets cut in half again to double the profits. By the time it gets down to the street, the heroin is only

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about anywhere between 8 and 12% pure. Now, if you're using that grade of heroin, it will take longer to become hooked than if you're using pure heroin to begin with, so that the length of time is dependent upon the dose, upon the frequency of administration, on the body build of the individual, on his age and there are many factors but roughly a month to six weeks would do the trick for almost anybody if they used it steadily.

Question - How do we establish the communication you alluded to between the teachers and the medical profession and the parents and so forth? How do you get in touch with an individual physician ?

Answer - Many people, especially in our areas, do not have personal physicians. They go to a group - a medical group or some kind of clinic. In urban areas and in some areas of Long Island there are no personal physicians - people go to a hospital clinic or to a public health clinic. Now, when the teacher tries to establish contact with the physician, everytime she calls the clinic she gets a different person and nobody knows quite why or how that drug was prescribed or what the condition is and this is extremely exasperating. In those instances where the school district has the services of a social worker, this is part of the social worker's job description - to maintain these liaisons. Another neglected person in all school systems is the school physician. Now, this is largely perpetuated, this neglect is perpetuated largely by school physicians because they take the title and they take some responsibility but they tend to avoid becoming involved in these situations and it occurred to me that if any physician who is a school doctor, upon inquiry from the teacher regarding one of the students, is unwilling to explore the situation and either contact the other physician or to give some assistance, then he ought not to be the school physician. In high school systems where there is fairly widespread use of drugs, it has been our experience in the last year, that a kid would overdose in class or in study hall and require immediate medical attention and the school

physician would be called and he would say if it's a drug case I don't want anything to do with it. Now, in my book, it's incompatible for an individual to say he's a school physician without becoming involved in drug reactions and it's something that will have to be worked out. In both Nassau and Suffolk counties, the Acadamies of Medicine are conducting in-service workshops with physicians. See, this is another myth that I hate to blast because I could lose my union card. But, actually, physicians are not the most knowledgeable people in the world about problems of drug abuse. They need to be updated and they need to be given in-service courses in this particular area and efforts are being made to involve them and to do this. Certainly, a teacher should work with the parents to find out, if possible, who this physician is.

Now, the final answer to your question - in special ed programs, it is a useful thing to contact local medical societies or the physicians listed in the yellow pages in that area, especially pediatricians, neurologists and psychiatrists, and invite them either to an Open House or to set up some kind of a program so that the local pediatrician can know what is going on in his school district. There's an abundant source of referral here which is not being utilized. In Huntington, where I live, the Pediatric Society meets in Huntington Hospital once a month. Once each year, they devote a meeting to school services and we have a joint meeting so that the physicians can update themselves as to what is going on in schools, what's available in the way of health services and this is a very valuable thing to do to promote these relationships.

Question - Would it be possible to become psychologically dependent on a drug like Dilantin?

Answer - It is altogether possible to become psychologically dependent and, as a matter of fact, it is possible for people to become psychologically dependent on capsules containing milk sugar or injections of distilled water. It's simply a

conditioned reflex that is developed. If a child in school is troubled because he is overactive and he's having a lot of difficulty and he's always in a hassle with his teacher and after a couple of conferences he's put on some kind of thing that he takes three times a day, you see, if then his behavior modifies because that's what is expected, everybody tells him once he takes the medicine he's going to be better in school and everything is going to be fine. The teacher relaxes because she's satisfied now that this kid is on some medication and she doesn't know that it's distilled water so that she, in turn, sees changes in behavior which aren't really there based on her perceptions. Now, you have a situation where the kid soon realizes that by doing better it's a nicer world to live in when I face it. Now he's afraid to give it up because if he goes back to the way it was, something terrible will happen and kids are easy prey to develop magical thinking, anyhow. You know, some kids can walk down the street on the way to school in the morning and take a stick and put it across a picket fence and hit every other picket. That day they take a test in arithmetic and they get a 90% and from that day on, they'll repeat this every morning on the way to school because that's the way you have a good day in school. They are so impressionable. They step on the cracks in the sidewalk or they avoid the cracks or they take a seat in the bus. They tend to be so uncompulsive in their behavior so now if you introduce something, especially from above down, they are very easily conditioned so that psychological dependence can develop very rapidly. I question the use of these things experimentally.

Question - Is there a special relationship between the illegal use of drugs and handicapped children?

Answer - No, I don't think that there would be a special relationship except as we've already alluded to that they may be more impressionable, they may be more conditioned because of having been given drugs to work out their conditions. If

they're mentally handicapped, they may, because of extreme naivete be more easily induced into something, to become couriers or accomplices on the part of some vicious exploitative children, but in terms of the actual use of the drugs in any kind of physical or mental handicap, I'm not aware of any special relationship.

Question - Are drugs prescribed indiscriminately?

Answer - Absolutely. You see, what you're doing now is identifying the problem as it exists in our entire society. The problem basically is that it's easier and simpler to change the person through chemicals than it is to change the situation which has created the problem. For example, in a school for emotionally disturbed children, you find a kid who, in the course of the morning, begins to act out and becomes assaultive and so on. This is a school for disturbed children and it seems to me that that behavior has to be understood, not necessarily tolerated, but understood and corrected in a psychologically sound way. There should be some facility in every school for the disturbed which is kind of like a quiet room. There should be somebody on the staff who can deal with that kid and talk him down out of his excitement. We don't do that. We either suspend him or tell the parents to get him on some kind of medication because that's a lot simpler but it's not really dealing with the situation. And this is also true in other areas of the society. Rather than deal with the basic problems, you see, we prescribe therapy whether it's chemical or some other kind and that may not be the best approach.

Question - This question has to do with teachers who leave teacher training institutions who may have been using drugs themselves during their college years and continue to use them in the teaching process. How does one handle that?

Answer - The answer to that question is you handle it the same way you do with students. First, you have got to catch him at it. Secondly, you have to depend on, I suppose, what is precisely the extent of the use and how it is affecting his

performance. As you will probably hear tomorrow - I think that's when you have the legal aspects of this - interestingly enough, there is no law anyplace in the country against the use of drugs or the abuse of them. The only thing that's illegal is the sale or possession, so that an individual can claim constitutional guarantee of his civil rights to abuse drugs as long as he doesn't get caught selling or possessing. But if he uses, that's something that you can't nail him on. Again, you would have to determine the kind of drug involved and I'm aware where this is leading us. There are a number of people, a rather large number, who have managed to cultivate the use of marijuana in almost precisely the same fashion that other people have cultivated the use of alcohol and they do not show any deliterious effects through the moderate use of this and they have managed to keep it under excellent control and it has not affected their performance. I think, during the big scare a couple of years ago, there was a teacher in California who volunteered the information that she had used two joints of marijuana every day of her life for the last 15 or 20 years, and from the moment she made that admission, she had troubles and was ultimately drummed out of the system. It would seem that her use during that time did not affect her performance so that we have to treat each case individually and be very careful as to how we're intruding on someone's privacy and their right to privacy. On the other hand, if teachers come to school freaked out or they're tripping, they still have the residue of the weekend trip and it's effecting their performance, then this is something that, naturally, has to be dealt with administrators. It's unlikely that a teacher would be using heroin routinely, because if he's really addicted to heroin, he can't spend that much time in the classroom and sneak out for enough fixes during the course of the day without being detected. So, that doesn't really become a problem.

Question - Why can't the politicians do something about getting the ads off television?

Francis C. Bauer, M.D. - continued

Answer - Simply because there's an enormous amount of profit involved and because people are corruptible. Now, those are two facts of life that have great bearing on the drug problem in our society. I would submit to you all that if we have the machinery in this country, if we have the machinery of government to remove cyclamates from the supermarkets within 72 hours after the drug administration said they are dangerous, then we could also do something about the controls of illegal drugs. The significant difference is that there is no profit in cyclamates and it's that simple. It is that simple. There is no reason that I can think of why ethical drug houses should overproduce barbiturates and amphetamines to the point that they can produce enough every year to allow about 75 doses per capita - man, woman and child - in the United States. This far exceeds the medical requirements and the vast majority of these substances end up on the illicit black market and come back in to be used by kids - the pill poppers. Now, why we can't influence them to cut back production to meet medical needs, again, gets down to one thing - profit. They have stockholders and drug companies are in business to make money for the stockholders and if people are using their products, they feel commercially no responsibility. And this, of course, is a problem in ethics in our whole society, in the whole business of marketing a substance for which nobody has any real use and then conditioning you subtly to buy something you don't need. You see, the morality of this can be questioned. For example, amphetamines. When you ask why do they produce so much Dexedrine and Benzedrine and the answer always comes back, it's very useful in the following conditions; for brain-injured children it tends to be a sedative; it's used widely in weight reducing programs - almost all of the weight pills have some kind of Benzedrine in them - and, thirdly, they say it's excellent, it's the drug of choice in the treatment of narcolepsy. Now, narcolepsy is a disease in which people have an unresistable urge to fall asleep. No matter what they're doing at the moment, they fall asleep - even going to the bathroom they conk off. It may last 30 seconds, it may last a minute. It's something like a petit mal seizure.

Francis C. Bauer, M.D. - continued

This is treated with amphetamines. I submit to you that I have been a physician for 20 years and I have never seen a case of narcolepsy and what's more, I don't have any physician friends who have ever seen a case in their practice and I suspect that it may be a disease of medical textbooks. But now we have the enormous production of a drug to treat a condition that exists, perhaps, in such a small percentage of the total population that it's worthless. All of these problems add into the consideration of drug abuse and it's not an educational problem or a medical problem. It's a total problem of society - every aspect of it.

I really would love to stay and answer more questions. I have another commitment and I beg you to excuse me. Thank you.

Methods and Materials on Drug Abuse

Mr. Fred O. Gehm

Earlier today you heard from Dr. Bauer. I'm certain he had a great deal to tell you about the drug information program that is presently going on in Western Suffolk. I am, primarily involved in the education of handicapped youngsters, servicing some eighteen component districts and approximately one thousand youngsters. We service deaf, blind, emotionally disturbed, severely retarded, brain injured and physically handicapped. Of that total population, the drug problem, if it exists, exists in the area of the disturbed and possibly in the area of educable retarded and we only administer one class for educable retarded so I guess you could say that, for the most part the problem is confined to our programs for the disturbed. In many instances the disturbed youngster comes from a deprived home situation. I question how disturbed he really is as opposed to being socially maladjusted or culturally deprived but we go on a basis of referrals from component districts.

My two colleagues up here may tell you about formal drug programs, formal programs of approach giving drug information. I'm going to tell you that this is not the key in special education. The key in special education is a closeness between the special education teacher and the youngsters in his charge. For the most part, we're dealing with eight or nine youngsters in a group and I would become extremely critical as an administrator if the teacher didn't know what was going on to a large extent. A good special education teacher isn't someone who punches a clock at nine, sees the youngsters for six hours, or five hours, or four hours and then sends them on their merry way and knows nothing about their personal lives. This is an individual that is involved. Some administrators feel that teachers should not be involved with the youngsters. I'm telling you that I'm one who feels that a good classroom teacher should be involved. A good classroom teacher should make home visits. A good classroom teacher should call in all the supportive services available. Yes, we do have a formal program but I think the informal program

is a great deal more effective. The formal program begins on the elementary level with our brain injured and disturbed population, simply because they're housed together. We begin with discussions about smoking and then we get into marijuana, narcotics, soft and hard drugs. For the most part, the program is carried out by our nurses, by our physical education staff and, in some instances, by our work-study people because they are involved with the older segment of our population. The key again, as I have seen it, is involvement of staff with youngsters. Now we can do a great deal more than a regular school population can do because we're small and because we have a high ratio of professionals to students. If a district attempted something like this, the cost would be prohibitive. Last year, there was a great deal of state and federal support for drug information programs. Many fine programs were initiated across the country. This year with the general cutbacks in education, drug information programs have been effected to some extent. Consequently, we found that districts where we were offering service are now balking because they are expected to pick up much of the cost themselves. Unfortunately, all districts are not as enlightened or sophisticated as some in Nassau County, perhaps, because we're under the gun financially and the taxpayer is overwhelmed by the tax load. What we stress is the relationship between our staff members and our students and we found it to be successful in most cases. This year I think we've had two cases of drugs that have come to our attention. We may very well have had more. In one instance, the parent of a youngster in our program was pushing and we caught him simply because we were on top of the situation. It was brought to the attention of the administration by the classroom teacher and we zeroed in on him immediately.

Mr. Arthur R. Coccaro: "Humanistic Approach to Drug Education"

As a society we tend to be creatures of singular, direct response. Rarely do we deviate from an essentially narrow, funneled vision pattern of adjustment. We attack the most complex of problems with simplistic vigor. Our society deals with poverty by handing out money, with lawlessness by incarceration, with inflation by wage and price freezes and with poor quality education by attempting to raise the number of dollars spent per student. Realistic analysis of any of these problems yield results that indicate the attempts at solving them are unrealistic, and progress can be made only when the attack is of the scope called for by magnitude of the problem.

Education's purpose is to eradicate ignorance; ignorance is the lack of knowledge - logically, education deals with cognitive input. The cognitive is divided into areas or departments, and the areas don't overlap. It's a simple and it's a practical approach to a broad, complex human endeavor. Math is the domain of the Math Department, and English is the singularly vested interest of those cerebral fellows with classes on the second floor. Drug Education stays in the Health Department and eighty percent of the program is education through irrelevant films.

But then again, this presentation is concerned with Drug Abuse, not with the irrelevancy of today's academic practices to the real world, and certainly not with the mindless practice of education as it is today. The sociological problem of drug abuse has been approached for the last ten years as narrowly as our society's responses to any of its problems. If we have a drug problem, educate about drugs - scare people about drugs - punish people involved in drugs, and workshop the drug problem to death. It only seems logical, we are an ends orientated society, the means, if they solve the drug problem are secondary. The reality of the situation is that the end (diminishing of drug abuse) is not even in sight.

Mr. Arthur R. Coccaro - continued

The methods (means) we have been using have done nothing except desensitize our youth. They are bored of hearing about drugs, "If I hear the word drug once more in school, I might take them to relieve my boredom." This comment, although more eloquent than most and kinder than most, is a typical response of today's high school student. I delivered what I considered was the finest presentation I have ever done on the Sociological History of Drug Abuse, and after inquiring about it, to my ego deflated surprise, my students related to me their boredom concerning the subject. "If it was about something else, I might have been interested, but I turned it off the minute you mentioned the word drugs."

What the students are verbalizing and feeling is that drugs are not the problem. There is no drug problem, there is a people problem. We've hidden out behind the cognitive long enough; a people problem requires a more human, affective approach. This is the type of program I am concerned with, and corterminous to this approach is the concept of humanizing the classroom through a mental health approach.

The intelligent approach to drug abuse deals with the etiology of a decision making process that leads to this socially unacceptable behavior. The causes of drug abuse are as varied as the personalities involved. They run the gamut from experimentation to psychotic depression. Our youngsters deeply involved in the problem seem to be deficient in three basic areas - self-awareness, self-confidence and understanding of social interaction. These deficiencies lead to alienation, loneliness, rejection, poor self-image, inability to fight improper group pressure and a generally poor mental health status. Dealing with these problems requires a total societal effort, an effort that requires work, that requires thinking, thinking that is too threatening to many of the educators and adults involved with our youth.

Education's role in fighting drug abuse is massive. It must equal the breadth of the problem. A total developmental, human approach is needed. Humanistic

Mr. Arthur R. Coccaro - continued

Education can be a start in a total effort to deal with our alienated, drug prone children. If your school is having drug days, giving lectures, bringing in police and ex-addicts, and the most ludicrous of all, showing scary drug films, and you are involved in making your classroom a more human place to be, you're the one dealing with the problem, you're fostering confidence, awareness and social interaction. You might make the school an alternative, you might relieve some of the pain inflicted in the classroom. That's what drug abuse is all about, relieving pain; we must offer a better way.

Mr. Stanley M. Lewis: "Drug Education and the Handicapped Child"

Out of the attic and into the outside world - step one in the rehabilitation of the handicapped youngster. Thanks to such people as the Kennedys and Humphreys, handicapped children have finally become part of our society - not as totally dependent individuals, but as independent, productive members of their communities.

Where parents of retarded or physically handicapped children were once reluctant to let it be known that they had a "less than perfect" youngster, today these same parents feel no shame in taking their youngsters shopping or visiting with them.

Through the efforts of such men as Henry Viscardi, Jr., youngsters once only educated through the homebound program set up by their districts, are now attending schools like Human Resources five days a week. More and more of these youngsters, once graduated from such schools, now go on to college. Hofstra University, Long Island University, State University at Farmingdale and Nassau Community College are a few of the colleges once inaccessible to handicapped youngsters. Now, with the use of ramps and elevators, these schools have given them the opportunity to pursue their education to its fullest.

One such youngster, a graduate of Human Resources School and Hofstra University (where he was president of the student council), is now attending law school and all the while on a litter (a reclining type wheelchair).

Back in those "child in the attic" days, there was rightfully no concern about drug abuse and handicapped children. Being confined to the house, the youngster relied totally on his family for all his needs. With more and more of these youngsters out of the house and of all things driving cars, they have found "the new world." Having attained this independence, combined with college life, socializing, and the difficult challenge of "being accepted", the handicapped youngster is now capable of becoming part of the drug culture.

Mr. Stanley M. Lewis - continued

Long hair, hippie type dress and rock music is becoming an ever increasing part of the handicapped youngster. If there is need in local school districts for a comprehensive drug education program, so is there a need for such a program in schools for handicapped children. Whether walking, running, or pushing yourself in a wheelchair, the drug culture is open to all!

Mrs. Glorya Selton

Drug Education is only taught for a portion of the semester of Health Education, a required course for half a semester in seventh grade and tenth grade in Central High School, District No. 3, Merrick. The emphasis in this particular unit is not on factual information. The focus is to bring into perspective the drug usage epidemic from the sociological as well as the psychological point of view in an attempt to help the student understand the psycho and socio-dynamics involved within individuals and groups which lead to the symptomatic use of drugs to resolve frustration and conflict.

The push to the use of drugs comes from emotional needs and unsolved internal personality factors of which our young people have little, if any, understanding. Health Education for us then, is focused upon human concerns and values. We deal with health as a state of physical, mental and social well-being, not merely the absence of disease. It is more than being well; it is having energy and enthusiasm for life's activities. It is having a good attitude about oneself and others. It is accepting the fact that life has problems but that one works toward the solutions or the modifications of these problems.

We attempt to do this by utilizing many group dynamic techniques to get the youngsters actively involved in what is happening. Suppose we try some of these right now.....

Tell Me

1. Look around and join up with someone you do not know.
2. Each tell your partner....What makes me happy....sad.... angry....and what I do when I'm angry.
3. Talk about this with your partner.
4. Now join up with another twosome that neither of you knows very well.

5. Each tell the others....What makes me happy....sad.... angry....and what I do when I'm angry.

6. Feedback from total group.

Now do the same thing imagining you are a handicapped student.

Feedback from total group as to feelings.

When we talk about drug education we are concerned with the student having some insight into himself as well as some concern for his fellow student. I would like you to try an activity that we use in the secondary school that would be applicable on any level.....

Trust Walk

1. Look around and join up with someone you do not know.
2. Each of you now has a responsibility for the other.
3. One partner will close his eyes and keep them closed.
4. The other partner must now lead his partner all around the building, making sure he prevents his partner from any unsafe situations but allowing his "blind" partner to experience many different experiences, such as touching wall, light switches, etc.
5. There is to be no verbalization at all; you must make your partner aware of what you want without talking.
6. At the end of ten minutes reverse places, so that the leader then becomes the one to be led.
7. Feedback from total group as to feelings associated with being the leader and being the one who is led.
8. Discussion of purpose of activity.

In addition to group dynamic techniques we attempt to involve the youngsters to participate in dramatizations, either those professionally written or those the students have written themselves. We use hundreds of commercially prepared pamphlets and booklets so that the students can gain the factual information for themselves and then present it to their class members. The teacher assumes the role of advisor and guide, not lecturer.

It takes more than being a good explainer of the text to be a good health teacher. As educators in the health area we are primarily concerned with an understanding of the self as it relates to health concepts rather than the more traditional approach to curriculum.

Mr. Mark Groothuis - "The Legal Aspects of Drug Abuse"

A question came up, two nights ago at a dinner I attended. Because you're all teachers, questions come up as to what happens when you're trying to counsel a known narcotic user or addict. What are you supposed to do about it? I've been informed that there's a directive from the Health Department that you're supposed to report this to your superiors. In effect, the question is - What is the relationship between teacher and student with respect to this particular problem? Let me answer it by telling you there is a known privilege between attorney and client. There is a known privilege between physician and patient. These are recognized privileges. No attorney can testify to or report anything that his client tells him. A doctor is expected to do the same for his patient. Such a privilege between teacher and student is not yet legally recognized. A recent case in Queens had shown that there may be such a privilege in certain cases. It's a lower court case and it isn't controlling in any manner. It would seem to me that one thing is clear, that the law doesn't provide for you to report such incidents to your superiors. It would seem to me that's between you and your conscience and, in effect, your superiors. I would suggest to you that it is a moral judgment which you must make for yourself. If there is some authority to the effect that there is such a privilege, it is not yet recognized.

Secondly, let me tell you that, I am a trial attorney with the Nassau County Legal Aid Society in the Criminal Division. I have tried many kinds of cases, including a number of drug and drug-related cases, but you must bear in mind that while the trial is probably the most significant, interesting, important, exciting, involving and even entertaining part of my work, it is really the part of my work with which you are the least concerned. As educators and parents, you're not interested in seeing your student or your child in a court of law. You're interested in seeing your child or student helped, guided, rehabilitated. You don't want to go to trial.

The very last element of the legal process in terms of criminal charges is the trial and once a case goes to trial, the student, boy or girl, is now a defendent in a criminal case and, as such, he has a lot to lose and the chances of conviction are not remote, no matter what the charges, no matter what the facts are or the circumstances. An attorney is a fool who tells his client that he will be acquitted. You see, prior to trial many things happen that usually result in the disposition of cases. For example, the system is so onerous and so annoying that one who is so unfortunate as to be accused of a crime is induced into taking a plea. The judge is interested in moving the calendar. He's interested in speedy justice. In effect, what happens, is a certain amount of bargain basement justice, in addition to the fact that on a sunny afternoon the judge may be interested in playing nine holes. But the point is that when the district attorney offers a plea, as he always does, in most cases to a reduced charge, prior to trial the judge is so generous on sentence that he will actually induce the defendant into taking a plea. Also, he will tell the attorney what his sentence will be or, if he doesn't specifically say what he will do, he will always hint or give a clue so that before taking the plea, the defendant is assured of what will happen to him. I'm not alluding to specific drugs at this point because this is what happens in all drug cases. Now anyone who has had any experience with the criminal courts knows, especially if a case is to be tried, that many court appearances are required and many hours of the day are spent waiting in the halls. Jobs are at stake, perhaps your job. The people just can't afford justice. They can't afford to miss so many hours and days of work. These are practical aspects. This is what happens, so, one takes a plea. This is the system. Your concern, ladies and gentlemen, is what happens before the trial for often, as I have indicated, there will be no trial. If your boy or student has a defense, the offer of the district attorney will be so attractive that the boy will be foolish to expose himself to the possible consequences of a trial and a conviction. First of all, and I mean this, I don't mean to shock you but he's

probably guilty, if not of the particular crime charged, he's guilty of at least something. It is a fact, that ninety percent of all defendants are guilty. The reason I say this is because if one actually becomes involved with the law, it is usually the inevitable result of his past activities, his staying out late, his hanging around street corners, his missing school, his poor motivation, his bad associations. Perhaps, in effect, this is maybe what the boy needs - a kick in the rear, something like probation to straighten him out. Here you've spent all your time counseling, holding his hand, but now another force is involved - the law and sometimes the law doesn't seem to care and perhaps, it might be good for the young man. What am I saying? What am I driving at? Let me tell you what a judge told a jury in a recent case. As a matter of fact, what every judge tells the jury in virtually every case at the beginning of the trial. The burden of proving the facts of the indictment always rests on the prosecution. Prosecution has the burden of proof. There is no burden on the defendant to prove his innocence. O.K. He's under no duty to present any witnesses in his own behalf. You will keep in mind at all times as the defendant sits here during the course of this trial, he is innocent until, the jury chosen determines, after listening to all the evidence, the openings, the summations, and the judge's charge, that the people have proven their case against the defendant beyond a reasonable doubt. Until that happens, he is as innocent as anyone sitting in this courtroom, as innocent as you or I. That's what the judge tells the jury. What utter nonsense. They call this the presumption of innocence and while it does exist this is nonsense when you're thinking about the young man who has been arrested, who has been handcuffed and has been placed in jail - there is a cloud over the head of anyone who is accused of a crime no matter what the law says. I've asked this question of juries and when I'm talking to a particular prospective juror, I always ask him "Does the mere fact that this defendant sitting here is accused of a crime, does that indicate to you that he is anyway guilty of anything" and sometimes I get, "Well, he wouldn't be here unless

something happened". Half of the time I get a "Nope, he's presumed to be innocent," but I don't really believe that most people believe this. I don't think it should disturb you very much that this is the way things are, because in most cases, you know it was inevitable that your student, that your child, would stray, that he would get into trouble. When a young man gets into trouble with the law, generally it's a culmination of a number of events. You knew that despite all your efforts, all your talks, all the steps you took to prevent such results, you knew he would get in trouble. So now that he's in trouble, what do you want? If he's technically innocent do you want his case tried six months or a year later. Do you want him to return to court six or seven times and go through a two, three or four day trial? Do you want to help round up witnesses, other kids who may also be hanging on their own precipice, to testify and to be cross-examined? Don't forget, we're talking about drugs, drug users and the legal process. We're assuming, and I'm assuming, that for the most part, we're talking about young men and women, teenagers over sixteen years old, who are using drugs. They've already got problems. No, I don't think that you want them to go to trial. You do want the case to be over with. In effect, what you want to do is pay the ten dollars for the speeding ticket that you didn't deserve and never have to come back. That may be an over-simplification but I don't think it's far from the truth. Let's talk about the truth, the guts of the legal process and our children, for that's what they are - children who tragically get caught in the web of legal process. You get a call at school or at home, a frantic call from a parent or the kid himself - I've been arrested, or my boy or my girl has been arrested. Maybe you don't get a call. Maybe you notice that Johnny wasn't in school yesterday, the day before or today. It's not unlike Johnny, but you are concerned. Sure enough, after calling his home and getting no response - his parents may not even know where he is. Perhaps, he isn't living with his parents, his aunt or his uncle and his uncle's not home. You talk to some of his friends and you learn he was picked up for possessing marijuana or hashish or barbiturates. These,

Mr. Mark Groothuis - continued

I think are the most common drugs with which you have the most problems - either a misdemeanor or felonious possession of the dangerous drugs that I've just mentioned. What is the first thing that you do? We're talking about a practical aspect. That depends upon where he is. If he's at the stationhouse and that's where you get the call from, you go there, you talk to the policeman, you indicate to the court that there are people who care about - not to the court, but to the policeman, that you want to cooperate, that you want help. If he's at police headquarters, you may go there. If he's at police headquarters he's already being processed so you may not be able to go there. If he's no longer at the station house when you get the call, chances are the first time that you'll be able to see him is in court. The hope is that you get a call from the stationhouse, that you are at home and that you'll be able to say, "please keep him there until I get there." Then you go in and all you do is talk. You talk and let people know that you're interested. If he's to be in court, as I indicated, when you first learn about it, then you go there. Now depending upon the time of day that Johnny is arrested will determine whether or not he spends the night in jail. For example, once arrested, Johnny is handcuffed, he's taken to the local stationhouse, as I indicated, for questioning. He also may not be alone - maybe two or three young people. Actually, no matter what time of day or night, he should be permitted to call his home or anyone who might be able to help, which might be you. It really depends upon Johnny. If he's cooperative, he will be treated properly. If he is obnoxious, uncooperative, uses foul language, well known words to describe the police officers, he may be questioned, searched, taken to police headquarters in Mineola for booking where he will be fingerprinted and pictures will be taken and then directly to court to appear before a judge at his arraignment. The children that you're dealing with I understand are either physically or emotionally handicapped in some way. Because of this condition, the young person is more likely to be misunderstood, abused, frightened or perhaps may appear uncooperative. This is unfortunate and that's all I can say about that. The

best way to understand this procedure is to illustrate with actual cases. Now at various times, especially when I first began working for Legal Aid, I was assigned to Arraignment Court for a particular week, as I am assigned from time to time. This is the place that all criminal cases begin. If you've ever been to court with a defendant, with a young person, this is the first appearance in court that he will make at his arraignment. It looks like this room. I'm the judge, Conrad Hecht may be the court reporter, we have a clerk and you people are either the defendants themselves who have been released, you might be the parents, the friends of defendants who are in custody in a detention cell or perhaps outside or, in the front row, would be the attorneys. The front rows are reserved for the attorneys. The attorneys get the best seats. They want to be closest to the judge. The calendar is posted outside of the court with the defendant's name, except police prisoners who were arrested the night before. There's been no time to record their names on any calendar.

I was sitting in the court room to take the cases which the judge would assign for legal aid and it sort of works like this. The young man is arrested the night before like I said and, perhaps, he does spend the night in jail. If he doesn't spend the night in jail, he might spend three or four hours at the station house, then go to police headquarters which would be open all night for booking and then he would be brought the very next morning into the court. In more cases than not, especially when you're dealing with young people, police officers are cooperative enough in that they don't want the boy sent to the Nassau County Jail. What they will do is keep the boy, make sure that he does get booked and they will bring him into the detention cell in court so that, in effect, he will not have gotten an hours sleep that night. It will just be one total traumatic experience but he will not have gone to the Nassau County Jail. That's where a situation exists where the police are generally cooperative.

Let's assume that he did spend the night in jail. Let's assume he's eighteen

year old and, perhaps in this case, I'll assume that he either lives alone or he doesn't live with his parents. He's indigent. Perhaps he's a senior or junior in high school who isn't going to school very much. Perhaps he's also a drug experimenter. I will not call him an addict. He is handcuffed and he is brought into the courtroom. The judge calls his name. He is ushered forward by the marshall or the court officer. Many times he will be handcuffed to another prisoner whose name will be called later. The judge quickly, because it's a large calendar, tells the young man what he is charged with and he asks him if he wants time to get an attorney. The judge will rarely take a plea of guilty or not guilty without a lawyer present. The judge is not interested at this time in the facts of the case. The case is not tried here and the judge is in a hurry. Unfortunately, it is of necessity. While in Nassau County this is the way it works, in New York City it's ten times as bad. If the boy says yes that he wants an attorney, then the judge will ask him if he can afford an attorney and the judge will ask where do you live or with whom do you live, are you working, are you going to school? If the answers appear to indicate indigency or poverty, the judge will say I assign Legal Aid to investigate the case and I adjourn the case for all purposes for one week. Now, comes the important part. If the defendant has a place to live, has a fairly clean record and the charge is not too serious, let's assume it's a misdemeanor possession of barbiturates, the judge will usually not set any bail and will release the defendant in his own custody. If he considers the defendant a poor risk, he will ordinarily set bail at five hundred dollars or more, depending upon the charge. If it's burglary, a felony, the bail might be a little higher. If it's robbery, higher. Quickly, the distinction between burglary and robbery - the difference between a pocketbook snatched from a woman walking down the street or picking up a pocketbook off the table. Well, in that case, the latter would be petty larceny, depending upon what's in the pocketbook. The first case it's robbery from a person. If the defendant's parents are in court, the judge will, if the defendant is fairly clean and the charge is not too serious, probably set a low bail or release the defendant and adjourn the case so that the defen-

dant has time to get an attorney, legal aid or otherwise.

Now the following week, the defendant appears with his lawyer, his own counsel or legal aid, which now may be a different legal aid lawyer or even a different judge and, at this time, with an attorney there, he will ordinarily plead "not guilty". The judge will set a date for a conference or a hearing, depending upon the nature of the case. This is a week later and these are the names that would appear on the calendar outside because the case has been adjourned for a week and now the case is on the calendar for his actual arraignment. While I said before that his first appearance is his arraignment, technically it's not correct. His arraignment occurs when he pleads and that would occur when he is generally with an attorney. The reason, very simply, why a judge will never take a plea the first time a defendant appears in court because the judge knows that ultimately most cases are disposed of and most cases will involve reduced pleas and the judge cannot take, will not take a plea, will not let a young man plead guilty to a serious misdemeanor or a serious felony.

I started to refer to an actual case. I was sitting in court and recognized some very dear friends of my parents. This has happened more than once. They were indeed embarrassed when they saw me but they told me that their son, twenty-three years old, was arrested for burglary and possession of heroin. They received a call late the night before and were told to be in court in the morning. They only had time to call their attorney in the wee hours and this attorney, their attorney, didn't absolutely know criminal work. They were referred to a criminal lawyer who appeared with their son in the morning. I asked them when I saw them if their son was in the detention cell and they told me that he was. They had not seen him. Their attorney hadn't arrived just yet and I happened to know their attorney and I had seen him earlier in the morning in another court room. I went to see the boy and I found him in the detention cell and spoke to him. This was his very first experience in detention and indeed is a very frightening one. Only

attorneys are permitted to see the defendants in the detention cell, not parents. So, as yet, they hadn't seen their son. They probably didn't sleep very much the night before. He told me he was working for a gardener during the summer and while working went into a house and did a very stupid thing and took some silverware and some silver pieces and this is a young man who didn't need money. When the homeowners returned and found the items missing, they called the police and told the police what must have happened. The police came to the boy's house, took him to the station house for questioning and arrested him. While being stripped and searched at Police Headquarters - the strip search is simply where the boy or girl is undressed, taken in front of three or four guards just to see that there's absolutely nothing that he can hide, nothing that could be used as a weapon or whatever. While being strip searched, two bags of heroin were found in a very peculiar place. I won't tell you where.

His name was finally called in court and he appeared with his parents and his lawyer. Because of the serious nature of these charges, the burglary and the possession of heroin, the judge set bail at one thousand dollars, which the parents immediately made arrangements to meet, being of substantial means. What I've told you in the last few moments is what happens the very first time that a defendant appears in court. The most impressive aspect of his initial encounter with the police and the legal process is, I think, of great concern to you for the following reasons. Young people everywhere we know have unique problems but your young people have problems which far exceed the usual. Your young people are deficient in some peculiar way, emotionally or physically. As a result, when confronted with undue stress, they are ill equipped to deal with the problem and consequences, as only you know, can be disastrous. I give you an example now of a young black boy who attends the BOCES School. He walked into a department store and while looking around, caught the attention of the store detective. Let's face it, store detectives have a tendency to look pretty closely at the young black boy who comes into his store alone or in

groups. They just don't look like shoppers. Unfortunately, in many cases, it happens to be the truth - they are not shopping. But this boy was alone. He was a young boy, approximately sixteen or seventeen years old and he was mentally retarded. The boy picked up an item which happened to be a sharp instrument, not unlike a knife. Apparently, while looking at other things that attracted his eye, he started to walk away with the knife-like item still in his hand. The store detective walked up to him and talked to the boy. The boy became frightened and when the store detective leaned over to touch the boy, the boy sprung back and cut the store detective with the sharp object. There was a question as to whether or not he did it purposely. The store detective naturally thought he did - I still am not sure whether or not the boy intended any injury to the store detective. Whatever, he ran, was caught, was handcuffed and he was jailed. When the charge of assault with a weapon was prepared, the boy appeared to have committed a very serious crime. As I indicated before, the judge doesn't know the facts and he doesn't want to know the facts. He's not trying the case at the arraignment part. So here a young black boy appears before the judge, very solemn, very quiet, very afraid and the judge looks at the piece of paper before him and on that piece of paper it says that the County of Nassau, the people of the State of New York charge this young boy with assault with a deadly weapon. What had he actually done? He got frightened and he ran. I later learned, when it was too late, that he was mentally retarded - after he had been in jail for a week. Naturally, ladies and gentlemen, this is the very kind of person who is most likely to be misunderstood. This is the young man who I think we're talking about this morning. Now that doesn't specifically relate to a drug case but let me tell you that one of the most common drug crimes is the drug related crime of shoplifting or petty larceny. The example of the young black boy is the usual case, whether or not the youngster is involved with drugs.

What I have done so far is to divide up the legal process beginning with what I consider to be and what you should consider to be the most important part and that

is the arrest. It is silly to even allude to the injustices of the legal process without considering first the trauma of the arrest. From all that I have said and the examples that I have thus far given, the one point you must always remember is that the first encounter with the authorities is a dehumanizing experience. What else can we call the handcuffing of a seventeen year old by a policeman, the incarceration of youths with convicted felons, drug addicts in withdrawal, drug sellers, and the like. What else can we call the experience of being stripped-searched, naked, hands against the wall - normal police procedures. Moreover, I can tell you from first hand experience the behavior of the court personnel, mostly the guards who carry guns, the marshalls, the sheriffs - is very often abominable. They push these people around, not particularly caring one for the other. There is no preference - everyone is treated alike, unfortunately, because they are not all alike.

You see, the difficulty is that to the police, the sheriff, the jail, the judges and, I must say, even many of the lawyers who are dealing with crime everyday, some matters must fortunately become, and very sadly become, routine. When that happens, understanding and compassion takes a back seat. Does the policeman care that a boy is retarded? Yes, if he knows, but he doesn't know and has no way of knowing. He has a job to do and when he sees a crime being committed or a crime is reported to have been committed, he investigates it and if he has a suspect it is his duty to investigate and take the suspect in. Today, of course, policemen are a little bit less careful with prospective defendants than they used to be. Policemen are not as a rule, as we know, our most educated public servants. It's an awful thought, ladies and gentlemen, to be treated as an animal in a cage. I don't think I have to embark on that too much but whenever I go back to the detention cell to see a client before his court appearance, I see mostly young people, slovenly in appearance except for the haircut that they've gotten at the jail rather inexpertly done. But these young people are no different from what you would see at the zoo. The only difference is, of course, that they are not animals. They are people in need of help,

mostly love and they cry out for it many times to deaf ears.

Now, one of the most unique problems faced in drug cases, and I refer to basically possession cases, is the problem of search and seizure. Most of the times the crimes are possession crimes. I believe, that in thinking about some of the things that I would say, naturally one has to be somewhat limited, I have purposely left out the detailed discussion of the drug sale which is a very serious felony. I don't think that the young people that you're dealing with are pushers. Occasionally, there might be a situation where a young person might be involved in accomodation sale. More often than not, your people are the ones who are the victims, the unfortunate victims of the small-time accomoda'ion seller and so I think that in most of your experiences, it seems that the problems that you're dealing with mostly would involve the possession of drugs. Again, it would be the marijuana, the hashish, the barbiturates, on occasion heroin and, generally, not in such great quantities that would amount to the possession with the intent to sell. There may be exceptions. If you do have questions, please don't hesitate to ask them at a later time and I will certainly be glad to answer. Specifically, the search and seizure problem which I think is the most important arises when a subject is searched and a seizure of contraband is made. The classic example is that of three eighteen year olds in a car being driven down Hempstead Turnpike. It is an old car with a defective muffler and the sound of the racing engine which is music to the ears of the occupants, WABC blaring the latest rock tunes, is somewhat disturbing to the police officer who pulls alongside and waves the car to the side of the road. The officer exits and approaches the car. He hears himself referred to as a rather sloppy-type animal and he observes some rather unnecessary gestures on the part of the occupants. He orders them out of the car and when the driver fails to produce his license, the officer calls for assistance and when assistance arrives, the search is conducted. In the glove compartment and in the trunk are quantities of hashish and marijuana, as well as barbiturates, all of which are in containers,

such as a paper bag. The officer asks whose stuff it is and he gets no response. They're all arrested. Now, I will say this, that when contraband is found in virtually all cases, the officer will try to find out to whom it belongs and if he does so find out, he will inevitably release the others. This is generally what happens. In this case, and in most cases, when there is no admission such as this, they are all arrested. This is the classic case of the unlawful search and seizure. The police officer, you see, must have probable cause to make an arrest. The search itself cannot give rise to the officer's probable cause. If the police officer makes a valid arrest, he may then make a search incidental to that arrest. For example, if he were to arrest the driver for driving without a license, which he could do, having made an arrest, he could then make an incidental search which, however, should not include the glove compartment or the trunk. That, you see, is a general search. If the car were to be impounded, there is case law which permits a search of the car for purposes of inventory and the defendant could be charged with items found therein, but these are not the facts that I have given you. Under the facts that I gave you, the police officer had no right to make the search. His theory, if the case went to trial and there were a hearing to determine the constitutionality of the police procedures, the evidence seized should be suppressed, which means that none of the contraband could be introduced at the trial. In short, the prosecution would have no case. Let me make this point. The chances are, in my example, the particular accused persons had long hair and they looked, well I guess, for want of a better word I guess they looked like hippy youngsters. Alright, we'll call them that although I don't like to use that term. And that is, perhaps, one of the reasons why he was suspicious and not without reason. I said that the prosecution would have no case if the evidence were to be suppressed. What happens, in fact, is a different story. The officer will tell a different story. I have with me the record of the search and seizure hearing in which three young people were stopped by a police officer. They were observed parked at a motel, one of the occupants got out, went

to a room. Now this officer was some fifty to sixty feet away and he says they caught his eye and was just watching them and he saw a transaction - what he thought was a transaction. He saw a paper bag being handed to one of the boys. The boy denied this, and then he saw the bay come back to the car, look around, the officer says suspiciously, and then got into the car and they drove away. The officer, after the car pulled away, pulled up alongside and he motioned to the car to move over. Let me tell you this that an officer has a perfect right to stop any car for an identification check. You could be driving innocently down the street and an officer can pull you over and ask you if you would kindly show him your license and registration. Now this is what the officer said. This is now direct examination of the officer by the District Attorney at the hearing. "What was the first thing you did officer upon pulling them over?" Answer - "I got out of my police car, I walked up to the defendant, the one who was driving, and asked him for his license and registration. He opened the window and as he did so I smelled a faint odor coming from inside the car." "From your experience, officer, what would you say that odor was?" Answer - "Marijuana or hashish." What actually happened was that when the officer stopped the vehicle, he ordered the three boys out of the car and he searched the car and he found contraband. He used the search to give him the probable cause to make the arrest and this is what he said at the hearing. I've talked to officers. Why do they do this? Why do they come into court and tell these stories? Not all officers are going to do this but most officers feel that the end justifies the means. This is their attitude toward this kind of story telling on the witness stand. This is fact. I, certainly, as a defense attorney don't approve of it and I don't think that the Police Department would approve it other than possibly tacitly. But this is the way it is. This is what happens. Of course, if the search is sustained as constitutional, and it is ruled that the contraband is not illegally seized, the defense has no case, unless it can be shown that the contraband was not

possessed by any of the defendants. Now, let me say this. In that particular case in which I felt that there was clearly unconstitutional search, the judge sustained the search as constitutional, based upon the officer's testimony and the judge will inevitably believe the police officer. Also, in that case, I guess I might add my defendant, and there were three defendants and I represented one of them, my defendant subsequently died of an overdose of heroin.

Now, at this point, you should be aware that if a dangerous drug is found in a car, it is presumed to be possessed by all the occupants. That is the law. This presumption is statutory and has been held in cases to be constitutional. What this means is that in a trial, in order for the prosecution to make his case, it is enough to show that drugs were found in the car and that A, B and C were in the car. On this evidence alone, because A, B and C are presumed to possess the drugs found in the car, they could be convicted. It is now up to A, B and C to produce facts which would nullify this presumption. The evidence may show that A, the driver, was the son of the registered owner, that B was coming out of class and A called to B and asked B to come to Berelli's for a pizza and that B was in the car but for a few moments. Based upon this evidence, if believed by a jury, B might very well have rebutted the presumption after the contraband's in the trunk and if B were seated in the back, the presumption might be rebutted after the contraband found in the glove compartment. The jury might have trouble disbelieving the police officer, however, and could easily find that there was an odor and if there was testimony that a cigarette was passed around, the jury might very well believe that B did partake. You see, it is not a crime to smoke marijuana. It is not a crime to use drugs. It is a crime to possess drugs and in order to be convicted of this crime of possession, the evidence must be presented in court, must be introduced so that nobody can be charged with smoking marijuana. You can only be charged with possession.

Now the ramifications are many with respect to search and seizure. Most often a defendant who tell his lawyer that the police officer tore my car apart will hear a very different tale in court. The lawyer knows this and the result will usually be the disposition of the case.

Let's return to the scene again and consider a different problem - the same facts except that the police officer asks, "All right, whose stuff is this? C'mon now, I don't want to have to take you all in. If one of you admits to possession, I'll let the others go." At this point there is some question as to whether or not A, B and C are actually in custody. Are they free to go? Well, I don't think the officer has said so but certainly the feeling of custody seems to pervade the surroundings, especially since it was testified to and let's assume that the police officer said, "Get out of the car slowly and carefully, hands outstretched." This is custody, and under the law, the defendant or any defendant must be informed that he has a right to an attorney before answering any questions. This is what we call the Miranda Law based upon People vs: Miranda in Arizona. If the driver has admitted that the drugs were his, because this is an admission, he is entitled to a hearing as to whether the statement was voluntary and whether he was actually informed of his constitutional rights. Now, the same mysteries will plague the police officer's testimony here and it is likely that he will say that the warnings were given when, in fact, they were not.

Now let me give you an example of what a truthful cop once said on the stand when he was asked the question: "Officer, did you give the defendant his warnings?" The officer says "Well yes." "What did you say to him?" "I said if he makes one move I'll blow his head off." "No officer. I don't mean that. Did you give him his Miranda warnings?" "No, I didn't have to. He wasn't Spanish." Now this is supposed to be a true account of what actually did happen. A police officer who did not know the law, was very unsophisticated, except for one exception - he told

the truth and in such a case, of course, any statements made by the defendant would, of course, be suppressed. Now, these hearings, these pre-trial hearings, are before a judge without a jury. If this statement is suppressed, the prosecution still has the presumption which can be rebutted, but let's assume that the statement is suppressed, the warnings were not given or that it was an involuntary statement, the People, the prosecution has left the possession or it has left the evidence, assuming that the search was sustained and they'll try to win their case without the statement, without the admission. It will be a little more difficult but they still have the presumption but if the statement is not suppressed, the jury should have little trouble with the case. I just will add this one point. At this pre-trial hearing, involving the statement, the jury can consider again the issue of whether or not the warnings were given. The judge first determines whether or not the warnings were given. If the judge finds that the warnings were given, the case is tried and the jury will be charged by the judge that they can determine that the warnings must have been given and they can determine whether or not the warnings were given and the judge cannot tell the jury that this was decided beforehand that the warnings were given. It's a two prong attack.

While it's important for you to know what could happen if the case winds up being litigated, and I mean tried, I think that it's more important for you to know what will happen nine times out of ten times. As I said before, the trial is probably the most interesting aspect of my work and it's probably the most interesting aspect of perhaps even this discussion, but I don't think it's going to benefit you because it's just not going to happen nine out of ten times. As I said before, nine out of ten defendants are guilty. It is generally a fact and while the boys may be technically innocent, they were guilty of something. Let's assume that B had actually said to A "Open your trunk, I want to put something in it and C and A did light up a cigarette of the grass variety and passed it around, putting the

rest of the drug in the glove compartment. I'm trying to point out that in my facts, these youngsters are guilty, although they might be proven to be not guilty. Of course, you see, I think that your concern is why have your students and children participate in such activities in the first place. Why should they get involved with the law. How can it be stopped. These are education problems. Certainly there are cases where innocent people will be duped into being associated with those who are in possession, who were charged with crimes. There are many cases where people are absolutely innocent and there is no excuse for taking a plea in these cases, and these cases should be tried, and I don't want anyone to think that any case that's presented to our office, especially to me, that we do not listen very carefully to the defendant and even though in our experience most of the defendants are interested in taking pleas because they feel that they are guilty or somewhat guilty that we don't explore the possibilities of going to trial. In many cases, possession cases, we have certainly gone for a hearing because we felt that we could win at the hearing and after the hearing have taken pleas because we felt that we couldn't win at trial.

What I'm driving at is your real desire when these young, unfortunate people get involved in law is to get the case over with and, if possible, remove any stigma attached to the accused as a result of his involvement. And this can be done. It can be done in many ways. In effect, this is how it can be done. If the charge is possession of marijuana in small quantities or hashish, the legislature has now taken a somewhat enlightened position in that the case will be adjourned in contemplation of dismissal. This means that after a period of time set by the judge, depending upon certain prerequisites, the case will be adjourned. No plea has been taken other than perhaps the not guilty plea at the arraignment. At the arraignment, a date will be set for a conference or a hearing, and at the hearing, the district attorney and the attorney and the judge will sit together - at least in Nassau County,

Mr. Mark Groothuis - continued

it's done this way - in New York City, I believe, there's an actual hearing where the disposition will be discussed and the provision goes throughout the state, this provision is applicable throughout the state. Any case involving marijuana or hashish, only marijuana and hashish, without the consent of the district attorney and without ever having been in difficulty before, a defendant has the right to have his case adjourned for a definite period, not longer than one year - it could be three months, six months - whatever date the judge picks and if he does not get into any trouble during that time, the case will automatically be dismissed. The case is placed in a file drawer and then at the end of that period, it is taken and placed in the disposed file. No plea has been taken. The case is certainly dismissed. The only pre-requisite, as I say, is that the defendant have no prior drug involvement and no criminal record. If he does have prior drug involvement or a criminal record, the same thing can happen but the consent of the district attorney is required. If there is a prior involvement with drugs or a criminal record, as I indicated, the case can still be adjourned for ultimate dismissal with the consent of the district attorney. Again, make sure you understand that this is for a definite period. The judge will set the date and he can set it actually at any time. This is what we call an ACOD - adjournment in contemplation of dismissal. If during that time the defendant would get into trouble again, the only way that the case, during this time now, can be taken out of that drawer into which it's filed, is if the district attorney chooses to restore it to the calendar. It isn't automatically restored if the defendant is arrested again. The district attorney would have to make application to have the case restored and then it's treated as if it were an original case. He may go to trial, plead not guilty, but you can see that the position of the legislature is that tampering with marijuana for the first time is not indicative of anything and the boy can be given an opportunity to not be subjected to a possible criminal record. It is a kind of self-induced probation, this adjourn-

Mr. Mark Groothuis - continued

ment in contemplation of dismissal, because only the defendant can get himself into more trouble and nobody is over him such as the Probation Department. It's purely up to him. When I say that if the defendant straightens out, I'm using it to define what the law will require this defendant to do. If the defendant, of course, persists in violating the law, the district attorney, as indicated, will restore the case.

Now, procedurally, I'm not trying to bog you down with details because I hope that what you are doing is placing yourselves in a position next to this defendant and going to court, thinking of yourself going to court with him and going through the case and the stages of the case with him. For example, this adjournment in contemplation of dismissal is ordinarily accomplished at a conference or a hearing and not during the initial stages, such as the arraignment and the arrest. You will, if you go down to the station house, see your defendant, you talk to the police officer, you cooperate with him. He then goes to court. A date is set for a conference or a hearing and it is at that conference or hearing that this will be done. So, already you've made two appearances. The district attorney must have time, you see, to check the defendant's records and if consent is necessary, he explores his background. No consent of the district attorney, as I said, is required in marijuana or hashish cases where there is no prior involvement, but in all other cases, consent is required. I say this of possession of heroin, possession of barbiturates, any drug cases or any misdemeanors. This adjournment in contemplation of dismissal is possible but generally the motion has to be made on papers with good reasons and the district attorney will not unreasonably withhold requests but he is not supposed to. But in all other cases except marijuana, the district attorney will generally require more in order for the office to consent to the dismissal.

For example, especially at this stage, it is quite doubtful that in a heroin case a defendant would be accorded this privilege. Let me just give you one example

of a heroin case. I had a young man, a black boy, who was charged with possession of heroin. He told me the story. He bought heroin. It wasn't for himself. He bought it for a friend and I believe him because this boy was too clean. He had too much to lose. He was a football player, a college football player. Alright, a number of his friends, as he told me, were addicts and he made this purchase because he was the only one who could get it for him. He was really trying to help him and he bought heroin with money that was given to him and he was caught. Here's a boy who is playing college football. He's quite a fine player and I've still been in touch with him. This is what we did in this case and what you might think of doing in certain cases where the charge might be as serious as possession of heroin. I had him testify before the Grand Jury, admitting all aspects of the charge because I wanted the Grand Jury to dismiss the case against him. It was a sympathetic plea and the Grand Jury bought it. The case was dismissed against him. What I'm saying is in many cases where the defendant is obviously guilty and the step that you want to take is to get rid of the case, you don't want to try the case, have him subjected to a possible criminal conviction, as this boy could have done had he gone to a hearing, had he gone to trial, he possibly coul have been convicted of a Class A misdemeanor punishable with a maximum of a year in jail and/or a one thousand dollar fine. Chances are he would have gotten probation but he would have had a criminal conviction. This way, the case was dismissed against him and his arrest record wiped clean, simply by admitting it and asking the Grand Jury to forgive him for his action.

Now, apart from adjournment in contemplation of dismissal, I feel that you would be mostly concerned with a disposition resulting in a condition with probation or a disposition as a youthful offender with probation. These are the kind of things that I think you would mostly get involved in. Before I touch on that, there is one other kind of disposition which is common. Let me cover it briefly. Presume Johnny is charged with possession of barbiturates. It's the first time Johnny has been in

trouble. The district attorney may not consent to an adjournment in contemplation of dismissal, but the district attorney will most likely offer a reduced charge if the defendant will plead guilty. If the underlying charge is a Class A misdemeanor, the most serious misdemeanor under the law, punishable, as I indicated before, the district attorney may offer either a Class B misdemeanor or a violation. While a misdemeanor is a crime, a violation isn't. Violations are usually disorderly conduct, harrassment, loitering and if the defendant does take such a plea chances are he will either get a very small fine, a slap on the wrist or a conditional or unconditional discharge. An unconditional discharge is simply don't let it happen again. A conditional discharge, theoretically, he is sentenced to a self-induced probation. Don't get in trouble for a year and we won't re-sentence you, a natural practice, it doesn't generally happen that way.

Youthful offender is something that you should be concerned with. Over the age of sixteen and under the age of nineteen, whether he's been in trouble before or not, an application should be made to treat the boy as a youthful offender. If he does take a plea, as a youthful offender, it is not a crime. He has no criminal record and if anybody should ask if he's ever been convicted of a crime the answer is no. Youthful offender is a device for placing youths on probation. Now, I must tell you this because this is very important. The area of disposition is the area in which you can be most helpful. Before a defendant is placed on probation, the judge always orders a probation-type report. So we now have a situation where the district attorney has reduced the charge, the judge has promised that I will put him on probation either as a youthful offender or he gets probation and the probation report is ordered. The boy goes to the Probation Department, he goes back to school, you ask him what happened and he says, "Well they're examining me, I went to probation." He's probably not even sure what

he's saying. He says, "Well, I think the judge may give me probation. I had to to to Probation where they're investigating me." At this point, if you know the judge's report is pending, while it is confidential, you may certainly contact the Probation Department to find out the boy's probation officer to influence and recommend to the officer, probation based on information that you have at your fingertips. With the proper effort on the part of the attorney and people like yourselves, it is rare that a youth will have to serve time. I will admit, however, that the drug area is particularly sensitive. Many judges have little or no compassion for the drug user and feel that once a needle is injected into one's arm, that person is an addict. I've heard Judges say, "I'm going to put this defendant in a place where he won't kill himself," and then the judge will proceed to sentence the defendant to a maximum jail term. When a young man is arrested for a drug crime, the judge at the arraignment will order examination pursuant to the Mental Hygiene Law to see if the defendant is an addict. This is a cursory examination, if given at the jail, it takes approximately five or ten minutes. If given at the Edgecomb Reception Center which I think is closed down now or Hanson Place where they might be sent now, it may take a little longer. They'll give a urine test at Hanson Place, they won't at the jail. In jail, the doctor just looks at you and asks how long you've been using drugs and he may get an answer or he may not get an answer. If he doesn't get cooperation, very often he will put down addict. He looks at the eyes, all the tests that you're probably more familiar with than I am and he'll either find him to be an addict or a non-addict. This is very important because if results are negative, the case is treated as an ordinary case. It goes through its orderly process. If the results are positive, before July 1st, if the defendant took a plea to a crime, a Class B misdemeanor, a Class A misdemeanor or a felony, he was to have a hearing to determine whether or not he was an addict because if he was positive, upon a criminal conviction he had to go to the Narcotic Addiction Control Commission for a period of,

Mr. Mark Groothuis - continued

misdemeanor now, up to three years, a felony, up to five. An indeterminate period. Generally, he would stay there from nine to eighteen months and he would go through various facilities. As of July 1st, all civil commitments are closed down. Many of the facilities, I think you know that the Rockefeller Program has closed down. There are some facilities open and they will take some criminal commitments but there's no more civil commitments, so this document sitting over there which I picked up "Help A Narcotic Addict," unfortunately New York State is back where it was. There is no more Narcotic Addiction Control Commission for the help of civil commitments to the best of my knowledge. July 1st we were told no more civil commitments. So, I will just tell you --- let me just give you one --- usually you're so involved. Your problem is merely to keep these young people out of jail, and out of a situation where they can be so abused and misunderstood and mistreated, because, as I said, the results would be disastrous. Now, what about the addict today. What can we do to help the addict? Again, the answer depends upon one thing. Is he in jail? If not, there is a lot we can do. My job, assuming I don't wish to try the case and risk conviction and adjudication of addiction for my client, is to adjourn the case and keep adjourning the case while efforts are made to have the defendant placed in one of the better drug facilities, if there is such a thing. Efforts made by yourselves. The important thing is to keep the defendant out of jail. I was able tp do this successfully in a particular case where the boy had three criminal charges. At that time there were civil commitments. I wanted to keep him out of jail. Even as a civil commitment, if he was civilly certified, he would end up going to jail till the NACC took the time to come pick him up. He might stay in jail for as long as two or three months. I contacted the NACC, had the NACC officer in court so that when the judge sentenced him to the NACC officer, he took him away, except that he didn't bring him to jail. He brought him to the Cooper Reception Center in the city where he was treated as an out-patient and he's now on a Methadone.

Mr. Mark Groothuis - continued

Now in conclusion, we'll discuss the drug crime. The law doesn't clearly indicate whether addicts should be punished or rehabilitated or whether the punishment is really rehabilitation or supposed to be rehabilitation. If the purpose is to punish, the system is doing fairly well but if rehabilitation is desired, the problem, of course, is quite different. What is needed is a national commitment, like the commitment to cure polio, the resulting Salk vaccine. The drug abuse problem is not a legal but a medical problem as we all know. It doesn't belong in the criminal courts. Clearly, the jails don't work. They only postpone the habit. In general, the drug program is not successful. Some programs do achieve noteworthy results but for the most part, they are isolated and infrequent. These programs are generally filled with motivated addicts. It seems to me that the biggest problem facing addicts is simply to be motivated enough to want a drug program. Most addicts today want Methadone maintenance and while Methadone maintenance is a kind of cop out in that it is a substitute, it appears to have an important percentage of success. There is one argument that I've heard for the free distribution of heroin. On the one hand, perhaps crime would be reduced because there would be no market for the sale of heroin and possession would not be a crime. On the other hand, if the body becomes saturated with heroin, even a controlled use, addicts may be reduced to harmless vegetables.

I haven't really discussed the law. I haven't discussed what the law is, what the sentences are, felonies, misdemeanors, all the different drug crimes or drug-related crimes. I think you know this and if you don't know it and wish to ask questions about it, certainly I'm available. I hope, mostly, that I've planted seeds in your minds for the important questions and, even more important than that, I hope that I've given you an idea of what you can do and what actually is done in a legal process to help young people accused of drug crimes or drug-related crimes. I've talked to many teachers and many people when they have come to court on behalf of young people, and it is their questions that have precipitated the remarks that I have made today. Thank you very much.

QUESTION AND ANSWER SESSION

"Legal Aspects of Drug Abuse"

Mr. Robert Sale - Supervisor of the Nassau County District Court Legal Aid Society

Mr. Hecht:

I hope you had a pleasant lunch and I hope you're ready to resume discussion on the Legal Aspects of Drug Abuse and the Handicapped Child. This morning, you heard from Mark Groothius and I indicated to you that he is an attorney with Legal Aid. Mark was called back into court by a judge who wouldn't wait and he very kindly informed us that his supervisor would be here this afternoon to answer your questions. Mr. Sale is the Supervisor of the Nassau County District Court Legal Aid Society, and is aware of the presentation that Mark made this morning.

So, with a great deal of pleasure, Mr. Robert Sale.

Mr. Sale:

Thank you, ladies and gentlemen. Being called on such short notice, I'm only generally aware of the exact nature of what Mark may have said to you. Maybe I can adjust by way of a few preliminary remarks and present to you one problem that struck me as I hastily drove over here today. The drug scene has caused a situation that attorneys now have to face which we never had in the past and which causes great consternation to us and to the emotionally disturbed. Throughout the years, law enforcement officials have thought to combat crime by undercover investigation. That is, in order to combat organized crime, other than wiretaps or hidden movies that we see on television, the only way the police could apprehend individuals was to infiltrate their ranks. The way they do this is have one of their members pose as a criminal, make a contact, actually live with the mob and then when the time was ripe, supply his information to a Grand Jury. Indictments would be handed down, arrests would be made and this individual would then appear in court with his badge on and testify against these people. That undercover technique was employed almost exclusively up until the post World War II or post Korea years. We now find that due to the

Mr. Sale - continued

tremendous insurgence of narcotics and dangerous drugs that the police are employing these techniques in colleges, high schools and even in junior high schools. Young narcotic agents are being infiltrated into the community. They mingle with the youth in schools and elsewhere and appear exactly like the other members of their peer group. Their hair is as long or longer, their language is the same and, in fact, they actually do participate in using drugs and committing acts that give rise to the financial ability for individuals to purchase drugs. And then, maybe six months or a year after a certain transaction, we, the attorneys, find our clients picked up in the middle of the night and charged with selling or possessing drugs six months or a year ago. The Grand Jury of the County of Nassau charges that on such and such a date they did normally and unlawfully sell drugs to John Doe, Richard Roe, etc., these names being undercover agents. When we confront our clients with "On this date, where were you?", they are unable to tell us. "On this date, did you ever sell or give any drugs to someone who you didn't know?" Well, not only do they deny it but they can't remember if they did because it's six months or a year later.

It's been necessary to employ these techniques and we raise all kinds of basic and fundamental constitutional questions, to wit, you must balance the equities. Are you going to deny a handicapped individual the opportunity to defense against this crime by virtue of the long passage of time, whereas you must balance that with the interests of society in protecting the identity of this undercover agent. He can't arrest the person on the spot because his identity would be compromised and his safety would be endangered. So, he must complete the investigation, go to the District Attorney and the Grand Jury and the arrest is then made many months later.

Now, ladies and gentlemen, you might be placed in a situation where a youngster you are working with is charged with a crime that may have occurred six months or a year or two years before. I suspect this would compound the problem that you would have in view of the fact the individual you are dealing with might not be able

Mr. Sale - continued

to assist in his own defense. If that opens up Pandora's box, I'm willing to tackle it but, at this point, is there anything that Mark mentioned this morning that you'd like to discuss?

Question - Drug abuse has a dehumanizing effect on the individuals concerned. The entire system dehumanizes the individual. What recommended sane legal approach do you view of this dehumanizing effect of the court, the police and the entire incident on the individual?

Answer - As an attorney, my function, regrettably, is to zero in on the legal aspects of a case. I am not nor do I pretend to be an expert in rehabilitation. My sole role in rehabilitation is in referring the individual to the proper person and, in that respect, I'm not qualified to answer your question. I can only tell you what legal steps I feel should be taken to insure that the individual gets a fair shake and to insure that he gets the necessary rehabilitation.

To ask me what legislative suggestions I have, I would like our narcotic laws to catch up with the state of civilization today. My personal opinion is that marijuana, which Mr. Groothuis may have indicated to you is a dangerous narcotic drug under our statutes, should be legalized. I feel if the day of legalizing it is not close at hand, then the penalties should be reduced to such an extent that for all intents and purposes, we have de facto legalization of marijuana, not de jure. Just this September 1st, the treatment of a marijuana offense, as Mr. Groothuis may have mentioned to you, was changed. If you are charged with a misdemeanor possession of marijuana and you have no prior record, an application can be made without the district attorney's consent, to have the charges "adjourned in contemplation of dismissal". In some period of time, six months or a year, the case will be dismissed and the entire record, including the arrest record of the individual involved, will be squashed. If he's asked if he was ever arrested he can properly say no.

Mr. Sale - continued

There is a recognition on the part of the New York State Legislature that marijuana should be treated differently from some other narcotic or dangerous drug. With respect to hard drugs such as heroin, I advocate with some modifications, the duplication of the British system. Treat it as an illness, license clinics to administer methadone and heroin to registered addicts and take the profit element out of the sale of heroin. I would call it the Heroin Control Act and have these people on probation to a heroin clinic where they would register and continue to take their heroin in controlled dosages. I would, on the federal level, attempt to stop the illegal flow of drugs into this country. Anything you do on a state level will be useless - unless this problem is attacked at the federal level because the great supply of our hard drugs comes in from other countries. I'm on the side of the defendant but I know how the police officers feel when drugs are so accessible and their apparent efforts are met with ridicule and turnstile justice in their view. So, in those three areas, I would advocate legalizing marijuana, registering and controlling the administration of heroin and other hard drugs and a concerted effort of strict federal laws to stem the illegal flow of drugs. Take the profit element out of drugs and treat it as a medical rather than a criminal problem.

Question - With respect to youngsters 18 and under and 15 and under, what special consideration is given to them legally and what does happen to them if they are accused of being in illegal possession of drugs?

Answer - By way of short review, if an individual at the time he is alleged to have committed a crime has reached his sixteenth birthday and not yet reached his nineteenth birthday, he is eligible to be treated as a youthful offender. That means he will be treated in the regular court system but all the proceedings will be closed and the penalties are somewhat less than if he were to be penalized under the penal law. If at the time of the act an individual is 16 and not yet 19, in most cases, he will be treated as a youthful offender. In the case of an individual

Mr. Robert Sale - continued

who has not reached his sixteenth birthday, he is treated as a juvenile. There is no lowest level of a juvenile. Theoretically, from the minute we're born we're eligible for juvenile treatment where cases are handled in the Family Court. An individual who is 16 or over is handled in the District or County Court, that is, the local Criminal Court or the Superior Criminal Court. In the Family Court, the individual, as in the District Court or County Court, is entitled to be represented by an attorney at all stages of the proceedings. The difference is that legally you are not entitled to a jury trial if you're under 16 and in the Family Court. When you have a trial, it is by a judge alone, whereas in most cases, you're entitled to a jury trial if you are 16 or over. Now, the Family Court is supposed to be in closer touch with the Probation Department because of the nature of their proceedings. When an individual is in a local criminal court, probation is not usually called into play until after the case is over. In a Family Court, as soon as the case is brought, the individual, if he's a youngster, is referred to the Probation Department and he begins with some sort of supervision and recommendations and/or care with the Probation Department. Society has legally drawn this line. The Probation Department will act as soon as the youngster is brought to court. Unless special considerations are given to him, there is no special unit for handicapped children. The only difference is that once the probation officer is made aware of the problem, it's his job and the attorney's job to advise the court. There is no branch of any court that I'm aware of in the State of New York that will step in and say, "Here's a handicapped child who needs some special kind of attention from us". It's all extra judicial attention and would have to be given by the Probation Department or through the attorney or through the family or through a teacher who is speaking for that individual. It does not come from within the court. It must come from within another branch, namely, the Probation Department.

Mr. Robert Sale - continued

Question - Would any consideration be given to the chronological age of the youngsters?

Answer - By that, do you mean at the time that the case comes to court? Or when considered chronologically, in other words, you're asking if a person was 25 but he has the mental age of an 18 year old, would he be treated as if he were 18? Unfortunately, the answer is no. The answer is no, regardless of any other measurement. If he chronologically has reached his sixteenth birthday, he's in the Criminal Court. If he's passed his 19th birthday, he's in the adult part of the Criminal Court. There is no recognition to any other barometer, unfortunately.

Question - As a teacher, it comes to your attention that one of your students is using drugs. It came to your attention by the student telling you, and that makes it a quasi-confidential communication. You take this knowledge and do nothing about it with respect to the authorities. You assist the student, the child. You try to guide him but you respect his confidence. You may even work with his family or through some other agency. Then, weeks or months later when an arrest is made, you are called on the carpet. What is your liability now, legally, having had this knowledge, having legally not divulged it to the principal, the police or the district attorney? Where does that put you and what should you have done initially to have avoided being put in this position?

Answer - I've given a lot of thought to it and as you did mention, unfortunately, speaking again from a personal point of view, the courts have not recognized the student-teacher relationship the same way they recognize, for example, a physician-patient relationship or an attorney-client relationship or a clergyman-parishioner relationship. Those relationships protect both parties from the right of incriminating themselves or the other party. They cannot be forced to disclose any communication received as a result of that relationship. You can't subpoena a doctor

Mr. Robert Sale - continued

without the client's consent to divulge something that he learned through the physician-patient relationship. You can't force a lawyer to divulge what his client told him about the case and the same thing with a clergyman of any recognized religion. Despite arguments of brother attorneys, the courts have not recognized the teacher-student relationship and that puts you in that quandry.

Question - Is there a way to legislate this privileged and confidential concept? Also, will the school nurse be treated as a medical or educational person?

Answer - A nurse can qualify as a physician in the sense that she is a registered nurse and she learned of this information from the patient. She is protected. However, if she learned of it from a teacher, and anytime either party to a confidential relationship discloses it to a third party, they then waive any claim they might have. You're not licensed to discuss this with a third party. The confidentiality of it ends. This is a legal concept again. But, I haven't answered the question yet. We can legislate it. In Albany, there was a new law passed this year. A new criminal procedure law went into effect September 1, 1971. If a successful lobby campaign had been conducted, Section 2841 could have stated, "A relationship will be recognized between student and teacher the same as the present attorney-client, physician-patient, clergyman-parishioner" or words to that effect. It could have been enacted. The chances are there won't be any amendments until at least January in the criminal procedure laws. The place where it has to be legislated is in Albany and teachers groups would have to make their views known through their representatives to enable us to combat this situation and to allow the teachers to act confidentially. For example, we have what is called Good Samaritan laws that enable physicians to stop at the side of the road and assist someone who's in an accident without fear of being sued for malpractice. If we don't have these laws, a doctor might continue driving. He might not want to stop and move someone and then be sued. So, to protect people in the public interest, Good Samaritan laws have been enacted.

Mr. Robert Sale - continued

Now again, to get back to the answer to what can teachers do when you're faced with this. You have to let your conscience be your guide. You must be aware of the fact that technically, you are an accessory, more or less, although there is no prosecution as such for an accessory after the fact. There are many criminal statutes where the district attorney could prosecute you. I feel, however, that if you make efforts in a rehabilitative direction, there is not one district attorney in New York who would prosecute you. If he did prosecute you, I don't think there's one grand jury that would indict and I don't think there's one juror that would convict you. And I would personally recommend that you continue in those efforts and respect your confidence. If you betray that confidence with an individual, your effectiveness, I feel, would be destroyed. Unless you saw the youngster was killing himself and you had to do something, of course, you're out for his or her welfare, first of all.

Question - If as the result of some information it was necessary for you to conduct a search on an individual and, in the course of the search, you came upon contraband in the form of drugs, what are then your responsibilities? Is it an illegal search and seizure?

Answer - It's not an illegal search and seizure. Illegal search and seizure refers to law enforcement officials. If you are not acting as an agent of the police and you're acting as a private citizen or a teacher, it is not an illegal search and seizure in the sense that the defendant can have the evidence suppressed at a trial. The only way it can happen is if you tortured him physically. The Supreme Court, when the case finally got there, would sustain. If you put a hammer lock on a child and took a burning match to his chin and threatened him in some other way and, by virtue of that, you're able to obtain some information or some drugs, I think the court would suppress that. I'm informed that the Education Law specificially prohibits teachers from searching children and I would assume you would not violate

Mr. Robert Sale - continued

that law. However, there are exceptions even to the Education Law, constitutional exceptions, and you could search a child if you had reason to believe, for example, that he had a bomb. Notwithstanding the Education Law, the police powers of safety and welfare would permit you to make a search. I would assume, and I don't know whether it's hypothetical or not, if someone told you that another individual had his pen, you wouldn't physically search him for that. If you lift his desk, you are not searching his person and it's a different issue entirely. What are your legal responsibilities if you find contraband? Your legal responsibility is to report it. No one can tell you anything else. If you find contraband, you must report it. If you find a stack of $100,000 with consecutive numbers, you must report it to the appropriate authorities. And especially heroin.

Comment - Mr. Hecht

This is an example of something that happened to me in my classroom. A youngster came in with an abscessed tooth for which he was taking antibiotics. He handed me the jar of pills and asked me to remind him to take one at lunchtime. I am legally charged with the responsibility of confiscating those pills because the only condition under which a youngster can take medication in school is if an Rx, a prescription, is in the hands of the nurse-teacher who then administers it. If a youngster comes in with a packet of pills, I am morally and legally charged with the responsibility of confiscating them. In the case in question, I told the youngster that I was much too busy and that I didn't see his pills. I reminded him when it was 12 o'clock because he wanted a drink of water at that time, and I assume he went out and took it himself. The boy came in with his jaw badly swollen. He was obviously doing this quite legally but I also have to be concerned with what I am supposed to do legally. You are not, under no circumstances, allowed to administer or aid in the administering of medication or drugs of any kind unless you are a nurse-teacher and unless, as a nurse-teacher, you have a written direction

Mr. Robert Sale - continued

Comment - Mr. Hecht - continued

from the physician. You cannot do it on the parent's say-so - you cannot do it on a telephone call - you cannot do it on a telephone call from the doctor or a note from the mother. It must be written out by the physician.

Question - From your experience, what would you as an attorney want from the educational field by way of assistance when you come in contact with the case until the case is over?

Answer - When we have a handicapped child who is in trouble with the law, generally speaking, the courts are sensitive to the situation and are sympathetic in the sense that they will go out of their way to see that there is the proper rehabilitation, for the reason that the penal system does not adequately deal with the handicapped prisoner. So, I must in all honesty say that any time I have asked for cooperation from any organization that has treated a handicapped person, I've always gotten complete cooperation. Frequently, before a case is disposed of, a judge will give the attorney an opportunity to sit down with him and discuss what's going to happen to this individual if he pleads guilty and comes within the jurisdiction of the court concerned. The one thing that organizations might do is have an individual available to physically go with the attorney to the judge's chambers and provide a personal history of the individual. When the judge sees a person come in in a wheelchair or on crutches or supported by his worker or mother, it's more meaningful than just reading 82 IQ or whatever the background has been, what medication he's taken, etc. Personal contact, I think, is invaluable and a personal appearance is very helpful. It's very hard for a judge to say "no" if you're persuasive and you tell him, "Look at the remarkable work this person has done. This is one mistake that he made. The effect of it on him is going to be catostrophic. We're not protecting society by incarcerating this individual. On the other hand, we're creating a burden on society by snuffing him out." Using all the arguments

Mr. Robert Sale - continued

that your experience dictates to you always supplies us with necessary information. Looking at the words is not as effective as having someone skillfully present them.

Question - In the many years that I have been engaged in my work, only on one occasion was I asked to physically come to support probation's position, implying that I probably was ineffective and, therefore, I wasn't asked again.

Answer - I think that it was probably because the Probation Department decided it wasn't necessary, but more likely it was the lack of recognition on their part. It's not only probation. We attorneys are to blame because we can't rely on the Probation Department entirely. We're not doing our job unless we are armed with every bit of ammunition at our disposal on behalf of our client and although it may be repetitive sometimes, it can't hurt. The more letters the judge gets saying how wonderful this person is and what a Jonas Salk he is, the less likely he's going to be to send him to jail. You might talk to the attorneys directly in some of these cases and you might even put it on the basis of you'd really feel much better if you were there. Even if you can't add anything to it as an observer, when you're there the judge is at least going to ask you to say a few words. And I wouldn't feel that anyone is going to resent the fact that you're pushing. You're concerned and the best way you can show your concern is by being there. I think it might have been a breakdown by probation or the attorneys. They should have you there more often.

Question - Where is the demarcation line between the legal possession of narcotics and the illegal possession of narcotics?

Answer - There are many situations that are spelled out in the public health laws and penal laws but, basically, any time a narcotic drug is prescribed or dispensed

Mr. Robert Sale - continued

to you by a duly licensed physician or hospital agency or any other agency that is duly licensed, you are entitled to possess or, as you say, use that drug. Of course, that license extends only to you.

Dr. John S. Sinacore - "Educational Aspects and Ways of Effectively Disseminating Information to Teachers and Children"

"The modern American....claims the highest standard of living in the world, but ten percent of his income must go for medical care and he cannot build hospitals fast enough to accommodate the sick. He is encouraged to believe that money will create drugs for the cure of heart disease, cancer and mental disease, but he makes no worthwhile effort to recognize, let alone correct, the mismanagements of his everyday life that contributes to the high incidence of these conditions. One may wonder indeed whether the pretense of superior health is not itself rapidly becoming a mental aberration." [1]

As a society, the mismanagements of our human health affairs can be attributed largely to two basic misconceptions. First, we have labored under the misconception that as we become more advanced as a society, we would ultimately overcome our health problems and reach that ideal of well-being man has always sought. Actually, the opposite is happening. As predicted by Rene Dubos, the very technology that makes life more comfortable and solves some of our health problems, also produces new and more sophisticated health concerns. A new drug may serve as an effective new treatment or as a death-dealing agent when abused. The controlled use of radiation can be life saving - uncontrolled it could destroy us all.

Because of the speed with which technological advances can take place and their ability to develop problems with short fuses, it becomes necessary to develop communication machinery with all age groups in the population. In this manner we can react as a society quickly and effectively to new dangers and problems. A well-informed population in the health sciences can also more effectively conduct health planning for the future. Health problems, therefore, can be anticipated and prevented, rather than reacted to belatedly.

1. Rene Dubos, Mirage of Health (New York: Doubleday, 1961) p. 31

Dr. John S. Sinacore - continued

Our society has also labored under the misconception that concerns for our well being should develop only in the absence of health. We are a problem and disease oriented society seeking treatments rather than preventions. We wait for disease to occur, then belatedly take action.

It is now known that the person with problems such as drug addiction, alcoholism, lung cancer, and emphysema is either beyond help or is already seriously damaged by the time he is seen by a physician. It must be recognized that the incidence of drug addiction, alcoholism, lung cancer, and emphysema do not in great part represent medical failures, but educational failures. Preventive education is thus a necessary vehicle.

The New York State Education Department is in the process of implementing a course of study in the Health Sciences that reflects the voluminous bodies of knowledge from the disciplines of medical science and public health. This course of study is heavily based on human ecology, namely a study of man in interaction with his environment. By environment we do not mean just those elements provided by nature, but also those aspects of environment introduced by man, namely pollutants of air and water, lethal cigarettes, the mass media, changes in medical care organization and administration, and the myriad of drugs now available in our society to name a few. It is becoming increasingly obvious that education directed solely at the individual with little regard for the many influences in his environment will be ineffective.

One objective of the study of health affairs is to bring some objectivity into the health classroom. We need to get away from the traditional format of the teacher telling the students the do's and don'ts of how to be healthy and lead the good life. Rather the student needs to be involved in the learning process not only for the purpose of coming to his own conclusions and making his own decisions, but also add his own constructive efforts to the resolution of societal health problems.

It is our definite hope to put to eternal rest the apple-a-day approach to

health teaching we have had in the past. To date, we have tended to measure health by health failures. We have attempted to evaluate someone's health status or the community's health status by the use of mortality rates. We know of course that there are varying degrees of health in that great range between life and death. We can assess visual acuity, degrees of overweight, degrees of immunity, sensitivity to allergens, emotional stability, etc. What we need to give students are various kinds of criteria for the measurement of health in the varying qualities in which it occurs.

In the area of nutrition we don't want to just be concerned with basic nutrition but with some of the shifting problems that we have in this area. There is for example, the problem of food faddism which is currently a billion dollar business in the United States. It is ironic that the best fed country in the world, one whose government pays its farmers not to overproduce, that enriches its bread with vitamin B and iron, adds vitamin D to its milk, iodizes its salt and adds vitamin A to margarine, should also have such an enormous, useless sale of vitamin and mineral supplements. The other question we must ask is why books advocating the use of miracle food and health foods persist on the best seller lists in spite of the condemnation of the American Medical Association and leading nutritionists? It is obvious that there is more at stake here than just nutrition. The erosion of the effectiveness of authority in any field spells trouble for a society (as we have also seen in the area of drug abuse.) How does it happen that a country with a highly developed educational system and mass media second to none can be so badly deluded and uninformed in so basic an area? The answer to the question, I think, is rather obvious. We have not effectively utilized our educational system to discuss problems of this type, and the mass media are serving up sales gimmicks with misleading messages that are condoned when they are successful in selling the product.

Dr. John S. Sinacore - continued

In the area of sensory perception we find that half of all blindness that occurs in the United States is preventable. Glaucoma, a leading cause of blindness, can be detected and, in most instances, the blindness prevented. Yet it persists simply because most people don't even know what glaucoma is, let alone what to do to prevent its deleterious effects.

In the area of drug education, more attention needs to be spent on the person rather than the drug. It is necessary that mental health education serve as a prerequisite to studies in the drug area. Unless a person has some understanding of his psychological self, he cannot possibly understand the motivations that underlie drug abuse. Yet, as we look at the schools in the country, we find almost without exception, curricula that focus in on drugs without so much as a glance at people and their inappropriate motivations for drug abuse. We have, for generations, taught the student about his physiological self but we have done relatively little in our schools to familiarize the individual with his more complex psychological self. This prerequisite to drug studies in part can be explained by the foreward of the New York State curriculum material at the senior high school level. It reads as follows:

> "There are many ways to leave this world. All people, in one manner or another, 'escape' temporarily through such things as daydreaming, sleep or alcohol. Others escape permanently through death or irreversible psychotic conditions. Some use drugs as a temporary escape only to find their ensuing addiction to be rather permanent. It is perhaps analogous to the astronaut who leaves his spaceship for a brief venture into space and finds that he cannot return. He is rather ironically 'trapped' in the vast regions of outer space. The drug user, likewise, is trapped in his fantasy world, never quite returning to a substantive reality. The escape becomes the entrapment.

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> It would be interesting to discuss and perhaps even argue the moralities and ethics one would associate with one form of escape as compared to another. As educators we need to involve our students in such a discourse along with supplying them with scientifically accurate information with regard to the nature and effects of those substances we are concerned with." [2]

Drug education should be more than just pharmacological study. In addition to mental health education serving as a prerequisite to drug studies, there must also be understanding of the physical, as well as the psychological, if the nature of drug dependence is to be comprehended. Disease entities associated with drug abuse such as hepatitis and their significance must also be common knowledge. Drugs and their implications for the area of safety also needs discussion. Rehabilitation programs related to drug dependent people, in order to be understood imply a knowledge of organization and administration of medical care in this country and all that entails. The area of consumer health education comes into the picture when prescription and non-prescription drugs and regulatory practices related to them are discussed. In summary, drug education should involve a study of pharmacology, mental health, public health, consumer health, physical health, and safety.

Our problems of environmental health most typify those of an advanced technological society as exemplified by the pollutants of air and water and the need for pesticide and radiation control. Increasingly, public health programs will be determining the levels of health that we can attain in our community. Unless our students know about these programs, and know how to relate to them, these public health programs may not be effective enough to control such basic things as the quality of the air we breathe, the water we drink and the food we eat. We have a

2. Overview, Strand II Sociological Health Problems Curriculum Material, Grades 10, 11, 12. p. 32

real job to do here with regard to the education of the individual about his public health responsibility. It is paradoxical to observe the almost hysterical concern that some express about the pollutants of the external environment while blithely using drugs, alcohol and other substances to pollute their internal environment.

The problems of consumer health are in many ways related to problems of environment. As stated by Dr. James Goddard:

> "We, as professionals in the field of public health, can lay out a wide range of concerns that involve those yet unborn, as well as those who drive, eat, fly, drink, and work, and even those who are lingering in the very shadows of life, soon to disappear. 'Consumer protection' is the phrase we have been using for many years. But who 'consumes' a drug before birth, who can be said to 'consume' urban noise, who 'consumes' the errors in laboratory analysis, who is a 'consumer' in a substandard nursing home, or who is <u>not</u> a 'consumer' of polluted air and water?
> We might conclude from this that it is not a 'consumer' who has captured our attention, but the quality and integrity of life itself--whether consumption in the economic sense takes place or not, or whether the individual we are concerned with is yet to be born or is on the verge of death." [3]

Educating the consumer is becoming increasingly important as lay people to a greater extent make the significant decisions with regard to health policies and programs. This is exemplified by members of boards of trustees of hospitals, school administrators, legislators, as well as each individual who makes personal, familial and societal decisions in the crucial area of health affairs.

3. Dr. James Goddard, Public Health and the Consumer. Delivered at the 63rd Annual Health Conference, May 24, 1967.

Dr. John S. Sinacore - continued

Health education is obviously more than the mere dissemination of knowledge. It also involves the development of values and even a life style. Confining this kind of instruction within the four walls of a classroom immediately restricts its effectiveness. Intellectualizing about health information in a classroom accomplishes limited objectives. If we are to realize the real goals of health education we must increasingly make this form of education experientially based. Health education in schools ideally should become an inherent part of public health programs with the student actively engaged in various field work experiences. If there is to be classroom discussion let it consist of strategy meetings on what is to happen in the community.....on how to effect the needed reforms in the conduction of our human health affairs.

Student involvement in the learning process should be all that phrase implies. Some high schools in New York State are already planning public health field work experiences for their health education students instead of requiring a term paper. The reports they will be responsible for will be based on their actual experience. Students from a New York City school, in cooperation with personnel from a local hospital, conducted a survey of 1500 homes in an effort to detect cases of lead poisoning. The students did turn up twenty cases of lead poisoning to the delight of their health colleagues at the hospital. In Syosset, New York, as part of their health education program, high school students are working in a program for mentally retarded patients in a nearby hospital. What better way for young people to better understand the problems related to retardation and what better way of overcoming the unfortunate stigmas too often associated with these conditions. The North Shore Hospital has established contact with a number of school districts so that it can effectively serve as a drug and health education resource, as well as a treatment center. The potentialities of this kind of effort are enormous.

The community is the laboratory of the health sciences. If the education

program of the school is to be effective it needs to have access to that laboratory. It can only do so if it has educators appropriately trained. It is time that we ring an end to the "amateur hour" role of the school, by professionalizing its role in the conduction of our societal health affairs.

To date there has been little or no contact between our medical and health science centers and our schools and teacher training institutions. Unless this contact is significantly increased the schools cannot be expected to play the key role they are capable of in the area of primary prevention. Where teacher training has involved representatives of the health sciences it too often is in the form of one or two week workshops in the summer. I wonder how many successful surgeons, pharmacologists, or psychiatrists we have trained in quickie two week workshops in mid-July. Or for that matter, how many teachers of mathematics, science or social studies have been prepared with such superficiality. The current health problems of youth which include not only the devastation of drug abuse, but the epidemic venereal diseases, the tobacco related diseases, the contradictory problems of malnutrition and the nutrition problems of affluence, the increased incidence of suicide and the basic need for mental health education demand our highest priority. The interrelatedness of some of these areas makes one wonder when we are going to put it all together in terms of an approach. It's time that we stopped thinking of a school health program as being separate from a community health program.

A school health education program must be considered an inherent part of the emerging new medical care delivery system in this country, playing a significant primary prevention role. It cannot serve a preventative function however, if health education programs are instituted only in response to problems that have already surfaced.

In New York State we are beginning to think about the development of health education centers that would consist of consortia of organizations. The organiza-

tions could include universities, hospitals, voluntary and public health agencies, academies of medicine, medical and health science centers.

A health education center would serve to train health education teachers as well as other health professionals. It would also serve as the health information center for the community.

In a modern technological society we can expect our health problems to become more complex and with shorter fuses. The drugs and pollutants of tomorrow will be even more sophisticated and potentially deadlier than those of today. Teaching about the adaptation to one's rapidly changing environment becomes a daily task.

If we are to effectively and rapidly respond to current and new health problems we will need to utilize communications technology now available to us. More importantly we need to develop a credible informational and experiential base with those to seek to communicate with. We have been frightfully slow in doing this.

Frustration that modern day educators as well as students feel with regard to the relevance of education was probably best expressed by an English teacher over thirty years ago. Her remarks are still appropriate today. Her statement is entitled:

I TAUGHT THEM ALL

"I have taught in high school for ten years. During that time
I have given assignments, among others, to a murderer, an
evangelist, a pugilist, a thief, and an imbecile.
The murderer was a quiet little boy who sat on the front seat
and regarded me with pale blue eyes; the evangelist, easily
the most popular boy in the school, had the lead in the junior
play; the pugilist lounged by the window and let loose at
intervals a raucous laugh that startled even the geraniums;
the thief was a gay-hearted Lothario with a song on his lips;

Dr. John S. Sinacore - continued

and the imbecile, a soft-eyed little animal seeking the shadows.

The murderer awaits death in the state penitentiary; the evangelist has lain a year now in the village churchyard; the pugilist lost an eye in a brawl in Hong Kong; the thief, by standing on tiptoe, can see the windows of my room from the county jail; the once gentle-eyed little moron beats his head against a padded wall in the state asylum.

All of these pupils once sat in my room, sat and looked at me gravely across worn brown desks. I must have been a great help to those pupils -- I taught them the rhyming scheme of the Elizabethan sonnet and how to diagram a complex sentence."

In view of the problems of today's youth and our society, in addition to teaching how to diagram a complex sentence, it is time.....God knows it is time.... that we teach about the complexities of life in a modern technological society and how one can suitably survive in our self-created, threatening environment.

QUESTION AND ANSWER SESSION

"Educational Aspects and Ways of Effectively Disseminating Information to Teachers and Children"

Dr. John S. Sinacore - Special Assistant to the Commissioner

Before you fire questions at me, I want to fire one at you. How many of you people in the audience, raise your right hand, have used drugs? O.K. That's the best question I've heard today. All of us are drug users and I think this is where we need to start. I've heard a great deal of discussion about drug use as though it were some kind of evil thing that we needed to be very cautious of. If I leave you with any message it would be this; don't create, in the minds of your kids, a fear of drugs because this is what a lot of drug abuse education tends to do when we have it negatively oriented. There is a proper and beneficial use of drugs and this is particularly pertinent to handicapped kids, a number of whom need to take drugs in order to help the condition that they have. If you ever create a fear of drugs in those people who need drugs, I think we're really in trouble. That's the kind of drug abuse turned around that we need to be very much aware of.

Now, it has been mentioned that parents should be involved in discussion and I think that's particularly true. I think most parents are drug abusers and I think it just takes a little time to begin to figure out which drugs they are. Everybody gets all excited about marijuana and drugs that are illegal. In the meantime, everybody's quite happy about people getting bombed on the legal drugs and I think we need to talk about drugs as drugs. Let's not pigeonhole them in terms of legal, illegal, drugs for the young and drugs for the old and begin to polarize the population in that manner. I think we need that kind of a broad base.

The other question I'd like to pose is - How many people have our curriculum material on Strand II? Now, those materials are being revised and are going to be made available via our computer-based resource units and they're going to start the initial materials at the 4th grade level. The new ones that are being developed will start at the 1st grade level and we don't think that's too soon. We'd love to

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see the parents made aware of the concepts that are being presented to the kids even at the 1st grade level right on through so that there is common understanding in terms of what we're talking about when we talk about drug education. If you write to my office, we'll be happy to provide you with Strand II. Some of the material on the secondary level is a little dated because we wrote that stuff back in 1966 but the material at the elementary level is still quite pertinent and I'm sure will be most helpful to you. Just write to my office and we'll be happy to provide it. You'll see Sarah Dunn this afternoon and you can ask her specific questions in terms of how to get the materials via the computer.

Are there any specific questions you would like to fire at me in the few minutes we have?

Question - How do you effectively use a peer group approach with children in special education programs and make it work?

Answer - First of all, I'd like to comment on your statement that peer group approach is a therapy session. I would not like to view it in that context. Although group sessions are many times group therapy sessions, in this case I would like to think of it in terms of an educational session, more than therapy. The other thing is that when we talk about peer groups, the peers that might be involved might not necessarily be other children in special education programs. In essence, if you've got a good health education program going in your school, there might be students from other classes that become a part of your program where the students might serve as assistant instructors. However, a prerequisite that I think would be necessary here is for those students to begin to understand the kinds of kids you've got in your class and what their capabilities and limitations are. Now, this I think leads into a whole different kind of thing but which I think is very necessary and that is, how much interaction is there between your kids and the non-handicapped. To what extent do the other kids understand these various kinds of

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handicaps that kids in special education programs have and how adequately do they deal with them. What I'm suggesting here is a program in education that would benefit both sides - one for the kids who are in regular classes to better understand the kinds of children you're dealing with and the specific problems that they have because, ultimately, these kids are going to meet outside of school in everyday interaction and there had better be this kind of understanding if your child is to make an appropriate adjustment and vice versa.

Now, with that kind of a background, then you've got some kids you can draw from who might, on a peer group approach, be most helpful in terms of communicating drug information or other kinds of health information to these children you're talking about.

The other thing that I think is a complexity here is the fact that we're talking about a wide range of problems that we're trying to deal with and some of the children you're dealing with, you could probably approach from a drug education point of view just as you would any other child. But others you would have to take into account the specific problems they have so that within this group there would be various kinds of approaches you would have to use because of the handicap your particular group has. We're talking about a multiplicity of things just within this group that we have to come to grips with, so that when we talk about peer groups, I think we're talking about peer groups that are possible within the problems that your children have, as well as peer groups from kids coming in from regular health classes. Now, these kinds of things have not been done before - we're cutting new ground here and I'd love to be able to lay out for you, 1, 2, 3 - this is what you do and at the end of it you know we're going to have the elimination of drug abuse. It's not that simple. What we're going to have to do is work together. The people who a year or two from now should be the real experts in this field are yourselves, because who else is going to be on the firing line digging out first-hand information as to what works

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and what doesn't work. All I can do as a so-called expert is to lay out some principles for you to follow and give you some help in terms of curriculum materials. You're the ones who are going to have to work it out. Now, one of the things that I would like to see happen is that as you try out curriculum materials that we make available, you respond to them and say this kind of learning activity works with a child with this handicap and this kind of material does not work for these reasons. What I would ultimately like to see is health and drug education materials that are specifically aimed at children with special problems such as the ones you are dealing with. Now, all we have to start with, really, are generalized health education and drug education materials which you would try out and apply what you already know about special education. We would hope that you will feed back to us what your findings are so that we can begin together to develop curricula that are aimed at these children. We're really in virgin territory in terms of this whole area and it's going to take years of work before we really get to where we would love to be, in terms of this kind of thing. The first prerequisite is, of course, opening up communication of this type. We think we have some ideas and I'm sure you have some ideas and we need to begin to share them.

Miss Sarah Dunn: "Computer Based Resource Units in Health Education"

I come to you from the State University College at Buffalo. My affiliation is with the college itself and also in connection with the special unit on health and drug education. I specifically represent a new division on our campus which I am very proud of, entitled the Research and Development Complex which is a derivative of the Professional Studies Division in Education and exists for the sole purpose of developing new curriculum, ideas and techniques and media, revising old curriculum, materials and so on. We are in the business of bringing to you, to the teachers, new ideas in curriculum development for all areas, including special education.

What I'm going to talk to you about this afternoon concerns ways in which you can impart all of the different basic knowledges and skills and suggestions in health education to your children, whether they be physically impaired or have any other difficulty or disability. What I'm going to talk about concerns all children and the import into the classroom structure with the health and drug curriculum of today. We were contracted by the Special Unit on Health and Drug Education to revise and continue development for the five basic health strands. These were to supply all teachers all of the necessary contacts and teaching suggestions in health education, including drug abuse. The strands that were developed for all of them two years ago were put into schools and after some evaluation and observation, were found to be somewhat deficient in providing the teacher with the proper direction or the proper approach for her particular class. The bulletins were set up in such a way that the teacher who wanted to deal with individual children or who wanted to deal with a particular type of child found these bulletins somewhat meaningless.

We prior to our involvement with Health Education, were in the business of developing curriculum for the individual child and have been working with the concept

of computer-based resource units. The concept of computer-based resource units in curriculum in education is essentially this. First of all, we have to develop a set of objectives that we wish to pursue, both long range and immediate. These goals we have to structure first so that we know where we're going with our particular class and parriicular child within the class. Number two, we have to know what kinds of factual material or factual content items we should impart in order to enhance those objectives. Then we go through all kinds of resource material and additional texts to find activities that the children can pursue in order to enhance both the contents now and the objectives ultimately. And then, of course, we try to develop proper evaluation tools to measure each child's involvement in the topic and retention of the content.

Going on this concept, we have developed computer-based resource units which are a sum total of all possible suggestions for the teacher in a particular topic area according to objectives, content, measuring devices, activities and resource material. We have provided this system with a data retrieval bank so that providing a proper method of coding, suggestions and appropriate suggestions to various learning situations, we have allowed the teacher the advantage of selecting the topic and selecting all the various suggestions that she finds appropriate for her particular class or for individual children in her class. Computer-based resource units are just that. We take a topic, drug abuse. We develop all the possible behavioral objectives that could possibly be associated with or pursued in that topic area, ranging in level Kindergarten through twelfth grade. In addition, we develop all the possible content or factual items that could be appropriately used in that topic, ranging from Kindergarten through twelfth grade.

The next thing that is developed for computer-based resource units is an entire list of activities for students, both large group and small group, and activities for individual students. The next unit is measuring devices and we develop all of

the possible kinds of measuring tools from standard tests to all kinds of activity type suggestions that could be utilized as measuring tools. And, lastly, we develop a section on the research materials that will be available in their particular topic area and we label the material and we anotate it so that you know what the material is, what type of child it is best suited for or where it can be purchased or, if it is free, where you can write for it.

After these five component parts are developed by teachers in the various fields of education, from the special education, physically and mentally handicapped, right on through to the regular classroom teacher, we code, in order that the system provides the teacher with only those suggestions that are appropriate for her class and only those suggestions appropriate to particular objectives that she wishes to pursue. There's a coding system which is merely a numbering system where we take an objective and we find all of the content and all of the activities and all of the measuring devices and all of the materials that are appropriate for their objectives and we assign these suggestions to the objective number to which they are appropriate for, so that every objective then will have content items, activity items, measuring device items and material items appropriate for that objective. The next thing we do is take all five component parts, including the objectives, and we code each suggestion to its appropriate variable category and general interest. We take the suggestion and we find general interest categories that it is appropriately suited for. Developmental tasks, reading level ranges, chronological age level ranges, mental age level ranges, the physically handicapped, the learning environment and so on, so that every suggestion has an appropriate range or is assigned an appropriate variable category. And, this, is the way in which teachers are able to select suggestions for an individual child or for her class because they are looking for suggestions based on a child's abilities.

After all of this text is written and the coding process has taken place, the

entire unit is put on a computer and it then becomes the computer-based resource unit. We'll use drugs and narcotics because this is a drug abuse institute and the tape has the entire unit. The teacher, then, by using an appropriate request system is able to make requests and keep only those objectives she has selected for her entire class, and all of the content, measuring devices, materials and activities that relate to those objectives. In addition, she is able to select one or two objectives for each one of her children and by quoting a particular student profile, select variable categories that suit the child's general interest, developmental task, CA, MA, reading level, etc. By feeding that information into the computer, she is able then to pull out a small program for each one of her children, in addition to her entire class program. For each student she will receive the name of the objective she selected for them and all of the learning activities and individual resource materials that are appropriate for that objective, and for the particular child's needs and capabilities. So that then she has not only an approach to take for her class but each one of her children are allowed an active part in the entire unit by having a program which is geared to their needs and also geared to the active involvement using activities and resource materials only.

All this serves two purposes. One, it certainly enhances the individual student's background and knowledge and interest in the particular topic. Secondly, the students, as they are working on their individual projects or individual assignments or on their special objectives, can bring to your class in the discussion as a whole, many more items, much more in the contributions than ordinarily would be made if he were just talking to one entire group. This is the basic concept of computer-based resource units and the basic approach in the development of the same.

Your concern is with the physically handicapped child and your concern is with

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good health education. What we have done now with our computer-based resource units is to take the five strands that were developed from the State Education Department and following this entire concept which I have just told you about, we have revised, updated and very seriously added to the strand that Albany developed for all teachers in New York State in Health Education. How many of you are familiar with the strands? For those of you who are not familiar, the strand bulletins were divided up into forty-three in number and each one of these bulletins ranges in the level of either K through third, fourth through sixth, seventh through ninth, tenth through twelfth, and they deal with specific aspects of one of the five individual strands so there are five strands but several sub-strands if you're familiar with them. We took all of this information and we developed, according to the computer-based resource unit approach, fourteen individual health units, a major portion including drugs and narcotics, alcohol, smoking, along with all of the other necessary areas of first aid, dental health and so on. Under the guidance of persons who had expertise in the various specific areas of the strands and sub-strands, teachers worked to develop all of the five component parts, objective, current and so on, develop these five component parts for each one of fourteen individual units. And then, after the text was written, we went through the coding process and, to date, we have developed nine full units on computer tapes with the remaining units almost complete, major exceptions being mental health and consumer health, because both must be carefully screened at the State Education Department level. The fourteen units available to you are Nutrition, Dental Health, Health Status, Disease Prevention and Control, First Aid, Drugs and Narcotics, Alcohol, Tobacco, Mental Health when it's finished, Consumer Health when it's finished, Environment and Public Health, Safety Education, World Health and Sensory Perception and, I'm sorry I missed one, Ecology and Epidemiology. Not every unit has been developed to date from the Kindergarten level to twelfth grade but they will be in the next year or two, and all units are available

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to every teacher including special education. Providing the screening is proper, that the suggestions and all of its content fit your program, the whole concept of approaching the individual child has been ours from the beginning and that is why we have utilized computer-based resource units in special education. This curriculum that I'm going to talk to you about is for you and has very serious implications for your individual children.

The concept of computer-based resource units has been, up to this point, for special education teachers, specially funded for you through Title VI, ESEA, and many of you may be familiar with the units that have been developed in special education and have, in fact, requested these strands by way of your regional special education and instructional materials center or strictly through the State University College at Buffalo. This is basically the same program. How soon will this information be available to me? Will I be able to receive it in the same way as I have previously or am I taken care of as a special education teacher and, in fact, what is the cost? Let me first clarify one point. The strand bulletins that were developed in Health Education will not be redeveloped again. We have been given this grant from the special unit in Albany and so, therefore, they are offering this approach to you in the area of Health Education. This comes from them as much as it comes from the State College at Buffalo.

There will be some small cost to this involvement. Based on the whole concept of computers and the whole idea of getting this information to you by way of a single computer or a few computers costs some money and, therefore, this system will be made available to you at some cost. The cost will be made to the school district by way of the superintendent and will probably operate in the same way as any type of large material or supply purchase. The computer-based resource units are disseminated from the State University College at Buffalo.

The portion that you as a teacher would receive as a part of the whole, we call

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a guide, so that you would be receiving a computer-based resource guide. The guide has to be generated by a specific request which you the teacher must make in your school. You make this request by studying a list of objectives, the behavioral objectives that are developed for that unit, by studying these objectives and selecting an appropriate objective range for your students. You must also have a sheet which gives all of the variable categories that you would be using to set your children's profile and you would also have to have a request form. Where do you get this material? When such time comes to pass, you would write directly to me in care of the college. The name is Miss Sarah Dunn, Research and Development Complex, State University College at Buffalo, 1300 Elmwood Avenue, Buffalo, New York, 14222, and my telephone number is 716-862-5433, no extension. I might add, if you want some information in addition to what I'm going to give you today, write for that right away anyway. What you will need to have in order to find that portion of the unit you want to work with is, first of all, a list of those objectives and secondly, a list of the variable categories, and thirdly, a request form with the appropriate areas that you have to fill in. Once you have received this request packet, you would, in looking at the objective list, find out that in addition to giving you the entire span, there is a description paragraph at the top of the list which tells you the approximate range of objectives that fit in the categories, rather the range of categories that fit in the range of learning abilities from Kindergarten to sixth grade and those objectives then fill the needs of the abilities from seventh to twelfth grades. This is given to you to allow you the structure to make a proper range selection for your class so that you know which objectives are suitable for the ability range of your class. It is flexible enough so that if you are teaching a group of children with ability ranges that fall in between those grades, that you have the opportunity to select objectives that go below or above, depending on the individual and the group ability. We base everything on objective selection. The teacher selects the objective range and then she has to set about the task of

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selecting those specific objectives. I don't have lists of objectives for you now. Here is an example of the request form and an example of the variable category sheet so that we can go through this together and learn the entire process of making a request. We'll assume certain objectives.

We have the two forms. Let's assume that we're working with a class of students who range in ability between fourth grade and sixth grade or nine, ten, eleven, twelve mental age. We're going to look at the objective list - let's use drugs and narcotics - and we're going to refer to the paragraph that I spoke of and we're going to find the range between K through sixth. Then we narrow this range down as we are looking at objective selections for the entire class. We look at from three to five objectives that we want to pursue for an entire class unit program. We look at five maximum because we find that many, many suggestions come out for each one of the objectives and it is a little too much or much too much for the teacher to pursue in a given time of six weeks. So we're looking at three to five objectives and if you will look at your request form, you will find that the form is divided up into three parts. The first part is the identification section which notes what school you are working in so that we have a mailing address for you and it makes note of which unit you have selected and the appropriate unit number. For every unit there is an identifying number which will appear next to it's name on every objective list. Assuming that you have all the objective lists for every unit that's been developed, you would have fourteen lists of objectives, fourteen individual unit titles, of course, for each objective list and a corresponding unit number for each unit and that's where you would get this information.

The second part of the request form is devoted to a section called the Part A section or that part that the teacher fills out for her request for the entire class. The teacher records her name and puts the numbers of the objectives that she has selected where it has group objectives. She doesn't code the objective name or the

description, just the number and underneath her name she would record the mental age range of her entire group from the lowest to the highest with a dash separating them. She must include that range because if she wants to follow the concept, she will want suggestions that are appropriate for that entire class, so she checks the MA ability range. And what does the teacher get then after she has selected three to five objectives for her class and has recorded the MA range? The teacher gets each objective printed out and for every one of those objectives, every content item, every large and small group activity, every measuring device and every material that is possibly quoted for that objective and for that particular ability range that she has recorded. What does it look like in a guide? This is a sample of a resource guide or that portion that the teacher receives after she has selected or made objective selections.

What does a teacher get in a Part A after she has made selections for objectives? Just to give you an idea so that you know why we limit her objective selections to five - remember we have five parts now. This is the sub-total of all the possible suggestions that will come out for the teacher for one objective. It's not the same length for every objective, of course, and certainly it would depend upon the range or how small the ability range was that she coded for, but this includes all the content, all of the small and large group activities, all the measuring devices of all the materials, so you see now why we limit to three to five objectives. That's what the teacher gets in a Part A.

Now, in a Part B, let's look at the second part of the whole process because the basic concept of computer-based resource units is the individualization of instruction or providing a program for each child suitable for that child's needs - and that's what we're here for. We're going to take some time with Part B for the

third section on your request form. Here is where the teacher starts making decisions about the individual learning profiles of each one of her children. Here is when she starts utilizing the individual variable sheet. Let's go through the variable categories to determine what they are and what is the method we use to apply them to the individual student categories. These variable categories have been utilized in all of the special education unit selections, with the exception of one which is Developmental Tasks, and we are utilizing that in health education units we hope to have it on permanent for all special education units. The first category is General Interest. We look at the student's needs and capabilities. We're also looking at the kinds of things that she or he is interested in because this facilitates learning, too, and if we can find suggestions that are appropriate to not only the need but also the interest, we're kind of, you know, close to home base. So, we ask the teacher in talking with the student or in student selection himself or in selecting for the student, to select three to five general interest categories that fit the child's needs and if the child is interested in a category that might not be related specifically to the unit that you are pursuing, you might, in selecting his own interest, pursue or assist him in pursuing interests that would be related. You have given him a chance to pick out what he wants but you're also leaning in the direction of the unit topic because of the nature of the coding and whether or not the selection isn't coded to the interest or not. So that's why we ask you to put more than less - put three to five, rather than one or two, so that you're sure to hit on some general interest category appropriately.

The second area is sex and this area is generally the same for both sexes - most every suggestion has been coded to both seventy-two and seventy-three so that this is not one that is - you can fill it in - but this is not one of the more important areas.

The third section, Developmental Tasks, we have divided this into two areas

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for K through sixth or middle childhood, and seventh through twelfth, adolescents. When the teacher looks at Developmental Tasks, she's again considering ability ranges of her children and she, of course, is going to look at one or maybe two within a given period of four to six weeks. Generally no more if she wants to really develop a particular task to its fullest. On the back then, we come to some of the more, I would say the more difficult categories as far as determination is concerned but, certainly, some of the more important categories in defining the child. Reading level, as you know by seeing is according to grade level, mental age and chronological age are according to age level. The mental age and the reading level is not always that easy to determine but we have an advantage because we're working with smaller groups, some of us, and we're working with children who have specific needs. We are fortunate enough to have, most of the time, at our hands, the tests and the kinds of information that we need to have in order to determine and because we're generally working in self-contained or close-knit situations with our kids, even if we do not have the information on black and white, the determinations can be made much more appropriately for our children than if we were teaching one-hundred-fifty students at a high school level and we only saw those students for maybe a period a day. And, of course, because this is a written kind of input and output, even though the teacher will be working with the student where necessary and if necessary, many of the suggestions that will be coming out rely very heavily on whether or not the child , one, can read, two, can read and comprehend, three, whether he can, of course, handle or be responsible for a task on his own, and so on. You don't want material to come out for the child if he cannot use it.

The seventh category on your sheet is Physical Handicaps. My apologies for the very scant category. It is hoped that we will develop this much more fully. There are many subtle handicaps that appear throughout regular classroom situations, many

more than not and with the new programs that are being developed in special education and in learning behavioral disorders and what have you, there's going to be a need to expand on this category. To date, we have the very noticeable ones which you have in front of you but we are working on revising and developing additional areas for screening.

The last, here, for you is Learning Environment which, of course, is narrowed to only three. When the teacher is looking at these variable categories, I might let you know that all of these categories are arbitrary in selection. The teacher only selects the objectives for a child. She does not have to paint an entire profile for the child or she might want to paint a limited profile, using only MA and reading level or she might want to be so specific as to record all areas as carefully as possible. The more stringent she follows the variable categories, the closer and tighter she paints the program for the child. The smaller the program will be, but the more geared to that child's needs. The looser she becomes in variable selection or, in fact, if she does not select any variable categories at all, she will just get back all of those suggestions and activities and resource materials that apply to the objectives and not necessarily to the particular child. So she has that flexibility but if she is concerned about the individual child's meeting his needs within the topic area, then she is going to use this Part B category and really paint a careful program.

When she has selected these variable categories for the child, she is careful to note that preceding every single variable category is a unique number. There are no two number one's. There are no two number two-hundred nineteen's. For a reason. When she records the specific variable categories for each child, she uses the number that precedes the category on the request form so that the computer will understand her language and read those numbers and interpret them back to the category she is selecting. Let's go back to Part A. Let's assume that we are looking at those objectives in Drugs and Narcotics for an area level of fourth

through sixth. Let's assume we have recorded the numbers of our objectives. Now we are ready to select our mental age range. We are looking at the mental age range category and we are looking at a range of, let's say, ten through twelve. The way in which we would record that range on our request form would be 207 - 209 and the computer would read back ten through twelve. So that's what I mean when I'm saying to select the appropriate number which precedes the category. Now the teacher has ten children in her class, so on Part B or the first section of your request form, she fills in the names of each of her students. Next to the names of each of her students, she fills in one or two objectives from the same objective list that hse has selected her group objectives, only one list of objectives. She puts down the two objectives that she or the student select. These objectives could be from the same set of objectives that she has selected for her group or they can be different objectives or they might be even out of the range of the objectives that she has looked at because of either a higher or lower degree of comprehension or sophistication about the child. Then she follows this selection with the appropriate variable categories and all of these categories areas are marked for you on the request form with one area, as you move along to read the categories, an exception. Body area is a category on your request form but we have not talked about it for a very good reason. It is only utilized in the special education unit and we would not use that for Health Education.

After she has recorded every student, the objectives for the student and his profile, she sends the request form back to me and I would, after checking it, send it to the computer and the computer would, in a few day's time, have back to me the resource guide which would be a result of your selection from the entire unit on Drugs and Narcotics. This guide would then be processed back to you by way of U.S. Mail. Once you have received the resource guide, your work begins. For you have done, up to this point, two things. You have reviewed the objective list and made appropriate selections according to objectives that have been printed for you since

you have filled out a request form knowing your students. The real job of the teacher now begins once the guide is in her hands. The guide, therefore, must be requested prior to teaching the unit because it is from this resource guide that the teacher draws those suggestions that she wishes to pursue. It is from the guide that the students begin working out their program. It is from the guide that the teacher and the student observe the kinds of materials that are necessary or that are available and begins to collect those wherever possible. The computer-based resource guide is a planning device which provides the teacher everything that has been written in the area and allows her an active participation in her class with her students where everyone is rolling up their sleeves and getting involved in pursuing or making the judgments, making the decisions what we are going to learn, how we are going to learn it, with it all there in front of you. It is not a lesson plan or a series of lesson plans. It does not tell you what to teach every day. It does not, in fact, limit you to that kind of a structure and depending on your particular school's program in Health Education, that would be the only area that you would perhaps be pursuing or considering when you're looking at contacts as to what you are supposed to teach in your particular school or area. But, otherwise, you are free to make the appropriate suggestion selections with your students because you have a particular class and your classes needs are different from another classes needs. This is, in a sense, what the guide is providing for the teacher. The fact that there will be a total of fourteen units that will be accessible to all of you, to all teachers and will be, in fact, available in providing direction for individual students based on individual needs. It provides another advantage for the teacher and for our whole system. With the computer-based concept, you can continually keep material up to date within a reasonable length of time. Unlike a text - hard covered -, unlike brochures and pamphlets that are printed under one printer, there is no real beginning or no real end to the whole unit. It has started some-

where in a particular level. It does not mean to say it cannot go further down into pre- or early childhood education and so on. It, more or less, shifts and hangs up here at a range somewhere around twelfth grade and does not mean that there is a ceiling. And in between there is a whole host of empty spaces which can be filled in by adding new kinds of concepts, new kinds of discoveries, new things, new people and also provides for the deletion of any obsolete item of content poorly used or poor activities and out-of-date evaluation devices and, certainly one of the biggest areas, out-of-date or obsolete resource materials.

In Health Education, we know that there is constant progress, there is constant change, constant new concerns that happen to come us. We've got to have information up-to-date. We've got to have the things available to us and this system provides us with that. You have to do a lot of work but your work is now in the classroom. Your work is with the kids. Your work is really getting involved.

I'm an educator first, I'm not a computer person. I have been in special education for eight years and I think we're going in a good direction now, in meeting these kids' needs head on and individually, finding the kinds of interests and the kinds of programs that they can pursue individually because this is their thing and a whole fresh new outlook, getting involved, not being hindered by the process of discovering and finding out all kinds of things.

I would like to thank you all for having me down here and really I look forward to hearing from everyone of you if you have a concern or if you have additional questions.

INSTRUCTIONAL VARIABLES FOR UNIT

ON ENVIRONMENTAL AND PUBLIC HEALTH

1. General Interest (select 3-5)

1. Philosophy
2. Psychology
3. Logic
4. Morals
6. Political Science
7. Economics
8. Law
9. Education
10. Commerce
11. Everyday Experiences
13. Language
15. Chemistry
16. Earth Science
17. Mathematics
18. Physics
20. Biological Science
21. Engineering
22. Agriculture
23. Domestic Science
24. Other Places
25. Animals
27. Natural Phenomenon
28. Creating and Construction
30. Photography
32. Drama
35. Geography
36. History
37. Sports/Leisure
38. Social Science
39. Physical Science
40. Natural Science
43. Art
44. Creative Writing
47. Early Days
48. Modern Wonders
50. Fun
51. Automobiles
52. Transportation

2. Sex

72. Male
73. Female

5. a. Developmental Tasks for Middle Childhood

74. Learning Physical Skills Necessary for Ordinary Games
75. Building Wholesome Attitudes Toward Oneself as a Growing Organism
76. Learning to Get Along with Age-Mates
77. Learning an Appropriate Masculine or Feminine Social Role
78. Developing Fundamental Skills in Reading, Writing and Calculating
79. Developing Concepts Necessary for Everyday Living
80. Developing Conscience, Morality and a System of Values
81. Achieving Personal Independence
82. Developing Attitudes Toward Social Groups and Institutions

b. Developmental Tasks for Adolescents

83. Achieving New and More Mature Relations With Age-Mates of Both Sexes
84. Accepting One's Physique (Male and Female Role)
85. Achieving Emotional Independence form Parents and Other Adults
86. Achieving Assurances of Economic Independence
87. Selecting and Preparing for an Occupation
88. Developing Intellectual Skills and Concepts Necessary for Civic Competence
89. Desiring and Achieving Socially Responsible Behavior
90. Preparing for Marriage and Family Life
91. Acquiring a Set of Values and Ethical System as a Guide to Behavior

4. Reading Level (Relative to grade level not age level)

103. Non-Reader	112. 5
104. Pre-Primer	113. 6
105. Primer	114. 7
106. 1	115. 8
107. 1.5	116. 9
108. 2	117. 10
109. 2.5	118. 11
110. 3	119. 12
111. 4	120. above 12

5. Mental Age

194. .5	206. 9.0
195. 1.0	207. 10.0
196. 1.5	208. 11.0
197. 2.0	209. 12.0
198. 2.5	210. 13.0
199. 3.0	211. 14.0
200. 3.5	212. 15.0
201. 4.0	213. 16.0
202. 5.0	214. 17.0
203. 6.0	215. 18.0
204. 7.0	216. 19.0
205. 8.0	217. 20.0
	218. above 20

6. Chronological Age

219. 0.5	231. 10.0
220. 1.0	232. 11.0
221. 1.5	233. 12.0
222. 2.0	234. 13.0
223. 2.5	235. 14.0
224. 3.0	236. 15.0
225. 4.0	237. 16.0
226. 5.0	238. 17.0
227. 6.0	239. 18.0
228. 7.0	240. 19.0
229. 8.0	241. 20.0
230. 9.0	242. 21.0

7. Physical Handicaps

243. Blind	246. Hard of Hearing
244. Partially Sighted	247. Gross Motor Disability
245. Deaf	248. Fine Motor Disability

8. Learning Environment

258. Classroom	260. Gymnasium
259. Outdoors	

REQUEST FORM

OFFICE USE ONLY

DATE RECEIVED:
DATE ENTERED:
DATE MAILED:

GUIDE ID:

SCHOOL NAME: _____

ADDRESS: _____ (Street)

_____ (city) (State) (Zip)

UNIT TITLE (U) _____ UNIT NUMBER _____

PART A

TEACHER NAME (TI) _____ GROUP OBJECTIVES: _____

CLASS M.A. RANGE _____

120

PART B

STUDENT NAME	INDIV. OBJ. 2 ONLY		GENERAL INTERESTS	DEVELOPMENTAL TASKS	SEX	READING LEVEL	AGE		PHYS. HAND.	BODY AREA*	LEARNING ENVRMT.
							MA	CA			

SCS-010-0

* For Movigenics Unit Only

Discussion Workshops

Workshop Leader: Mrs. Grace C. McCandless

Wednesday - November 3, 1971

Discussion followed presentation by Dr. Bauer.
Disciplines represented by group: one teacher of emotionally disturbed, two physical and health education teachers, four teachers of mentally retarded, two rehabilitation counselors, one nurse, five special education administrators.

The concensus of reaction to Dr. Bauer's presentation was that there is a lack of coordination among those working with the handicapped child particularly those for whom drugs are prescribed. It was felt that the educator could be the agent for coordination.

Suggestions for such an effort were various. That forms be used to permit an exchange between the physician and the school of the pupil's needs and his physical and emotional status. A stronger feeling was that the schools should reach out into the community and effect a sharing of knowledge of the child. This could be achieved through the committees in the county health associations. This has been done with some success in such communities as Rockland County. Another medium would be through articles in medical journals.

In the area of drug misuse (or abuse) the approaches suggested were different. Some participants felt that teachers needed education in this area. Others felt parents were not assuming responsibility. There was some question of the use of drugs for control of the hyperactive and emotionally disturbed child in a school setting. Perhaps this method was used since educational programs did not present sufficient alternatives to meet the varying needs of such pupils.

Thursday - November 4, 1971

Discussion followed presentation of Mr. Mark Groothuis.

The workshop members explored the role of the teacher vis-avis the drug abuser. There was some division of opinion as to whether the teacher was a case finder (reporter) or a counselor (suggester). It was found that the teacher is often bound by regulations in playing a role.

How to handle the school age drug addict was considered. Some felt it was better if he retained contact with school since other agencies, had failed. Rehabilitation could be based at the school.

Mr. Groothuis visited the group. He indicated that the courts would be sympathetic to the handicapped youth who had a drug problem possibly associated with his disability. If there is an interested agency the law is more lenient about arrest and persecution of the case. The released drug abuser needs to know there is someone to turn to when he is in need.

Societies attitudes and handling of the drug problem are changing. All agreed. However, there was no agreement among workshop members that drugs should be made legal for acknowledged addicts as in England. It was felt that there is a difference in resolving the problems of the "hard" drug addict and the users of "soft" drugs who are less apt to be identified as criminals.

The professional ethics involved in the use of drugs for control of hyperactive children was considered. It was noted that a conference had been sponsored by HEW on this subject.

Friday, November 5, 1971

Discussion followed the presentation by Dr. John S. Sinacore.

There were some strong reactions to the "humanistic" approach in sensitizing handicapped pupils to the dangers of drug use and abuse. All members agreed that the group therapy, if used with unstable pupils, had many dangers. Most of the pupils are in therapy for other problems. It would be difficult to control unstable peer group interactions. The adult leader must be trained and aware of his group as individuals.

Concern was expressed about the person to conduct the group sessions or any drug program with the handicapped.

Ex-addicts were not deemed suitable. All teachers are not adequate to the situation. In addition the program and the worker must have the acceptance and support of the community. It is difficult to obtain the cooperation of all agencies in the community.

The institute dramatically demonstrated the need for further similar institutes. It demonstrated that experts can be provincial or even isolated in their expertise. The planning committee had brought together people expert in the area of drug addiction on the one hand and persons expert in the area of the handicapped. It was apparent that within each of these areas there are unique knowledges and techniques. Up to the time of the institute these experts had not come together in common sharing of abilities.

It is obvious that the handicapped are a minority group which is little understood by the lay community and in many instances by professionals in allied fields. The question arises which group is most needful of a change of attitudes and acquisition of information. Is it the expert in the field of drug addiction or the expert in special education? Both groups evidenced serious lacks. I believe the institute initiated a process of cooperative approach in working with special problems as they apply to the handicapped.

All workshop members in my group expressed a need to come together again in the Spring in order to report on individual and committee progress in resolving problems growing out of drugs and the handicapped.

Since this institute was a "first" in this area I believe that the committee provided a framework for future conferences and a reference for the design, whether it be the same or different.

Workshop Leader: Mr. Gerald E. Moore

Wednesday - November 3, 1971

A general consensus of Dr. Bauer's address initiated the discussion. Most of the comments were favorable, such as "very informative," "interesting," "enjoyable."

Discussion followed on the practicality of carrying our Dr. Bauer's recommendation that consultation between school officials and pediatricians of children on medication be done on a monthly basis. It was pointed out that:

a. Pediatricians do not have the time to spend in consultation with school officials.
b. Pediatricians may not cooperate because they would not get paid for this service.
c. Isn't this being done by school nurses now?
d. Did Dr. Bauer infer that we as teacher should communicate on a monthly basis with the pediatrician? Many in the group did not see this as the responsibility of the teacher, but rather the responsibility of the parent and school nurse and/or social worker.

In his address Dr. Bauer elaborated on the dangers of anti-convulsive drugs, especially those containing phenobarbital. A member of the group asked, "Out of the twenty-two anti-convulsive drugs and sixty-four tranquilizers to choose from, what leads a doctor to choose a particular one? Specifically, why prescribe medication containing phenobarbital when others are available? It was pointed out that phenobarbital is the only anti-convulsive medication with long-range effects, and is sometimes necessary for the user.

The intensity of the drug abuse problem among the handicapped versus that of the "normal" population was discussed. It was agreed that the problem existed to a great degree in both groups.

Art Coccaro's remark that teachers must begin to deal with youngster's emotions was discussed. The group agreed special class teachers have been doing this for a long time.

Thursday - November 4, 1971

The general consensus of Mark Groothuis' presentation was favorable. The reactions to the address were good, stressing that Mr. Groothuis had clearly defined the legal aspects once a youngster is taken into custody.

Discussion led to teacher involvement with youngsters in trouble with the law. Is it not necessary to find out what the school policy is re a teacher becoming involved in "outside of school" matters? Do we go ahead and try to help the youngster regardless of school policy?

A discussion on police corruption followed.

Teacher confidentiality? - How much information is a teacher permitted to hold back? Can we help a youngster more than the authorities? The general answer was "yes." The existing programs and facilities are not serving the needs of the youngster. It was agreed that teacher confidentiality was a matter of individual conscience.

Friday, November 5, 1971

The address on the educational aspects of drug abuse was said to be boring, uninformative, and of little value. All that was mentioned were future plans of the State Department in the area of drug education.

Individuals gave their accounts of personal involvement with youngsters in their classes, and how this personal involvement helped the youngsters. This appeared to be a necessary responsibility of each teacher.

A discussion on the evaluation of the conference took place. Some members of the group would like the opportunity to speak to youngsters with drug problems.

Workshop Leader: Mr. Russell V. Riggio

Wednesday - November 3, 1971

The program should have mentioned other school disciplines and their roles regarding drug education.

The role of pharmacist should have been included.

The point about procedural matters regarding use of drugs in schools is of particular value.

Does the special education student have a unique problem regarding drugs? Does each handicap have its own special problem? These questions remain unanswered.

The deaf are five years behind their hearing counterparts because they are insulated from mass media.

Typican special education students shy away from strangers and would tend to be involved with school friends. Therefore, drugs are not a problem to them.

The handicapped are more prone to use (misuse) legal drugs.

Approaches to the problem:

a. special approach to each handicap
b. look for common ground in each handicap
c. young are much different from older handicapped
d. parent education
e. mental health approach

If we stress "normalization" -- will this lead us to the typical drug problem?
will we have it in the future?

Physically Handicapped - small drug problem
Emotionally Disturbed - "swap" pills - more of a problem
Marginal Handicapped - a much greater problem

Thursday - November 4, 1971

Feelings of what would be the proper approach as a result of the whole three day program.

Maybe the college students who are handicapped could have been used for first hand experiences involved with handicapped vs. drug abuse, mental health.

Parents not mentioned as key persons to spearhead the approach to drugs with the handicapped child. Although the educators seen to be more involved with children and, therefore, seem to have more impact and/or responsibility.

Not enough hospitals willing to cooperate with educators, e.g., tours geared toward drug abuse.

Are there different reasons for handicapped children to indulge with drugs vs. reasons normal children take them?

What are the variety of reasons among the handicapped that may be similar or different from the normal?

Discussion panels geared towards humanizing the curriculum for the child. Given choices for manipulation rather than a narrow outlook of the system of education. Attitudes are the key values in looking at all problems.

Approach should be geared to rap sessions rather than the formal assembly technique for the purpose of stuffing drug information into students.

Friday - November 5, 1971

Topics Discussed

The pertinence of the morning presentation, i.e., the shoplifting incident. No mention was made re the elementary age group or the legal responsibilities of the school or the teachers. The school nurse-teacher's position was not mentioned re privileged communication. We questioned whether or not the law gave any special treatment to handicapped youngsters.

We mentioned the changing role of the schools now as well as in the future. It was noted that the school can only administer first aid re symptoms of "overdose" -

- they cannot diagnose or treat.

We discussed administrator's responsibility re "pushers" in the school; and the school's role re students involved in off campus "drug activities."

We discussed the "rights" of the child, drug related behavior, and our legal right to request a urinalysis.

Corporal punishment in New York State schools was discussed.

Disagreements

Are we asking for special dispensations for our handicapped students?

Are teachers responsible for their students out of the school setting?

Procedures used in dealing with a drug abuse case in school.

Extent of the school's role in disciplining a student who has injured a peer in school.

The trespass upon a student's "rights" if an arrest is allowed to be made in a school.

Agreements

The types of questions to be presented at the p.m. session.

The obvious "Frame of references" prejudice of the speaker.

The lack of communication re school drug policy and law enforcement.

The law is written for the normal population with no provision for a handicapped individual.

The teacher's role is and should be extended into the community.

Parents look to the schools for assistance, i.e. requesting urine tests.

A youthful offender may be tried more than once as a youthful offender.

Corporal punishment is legal in all of New York State except New York City.

Teachers should not always be so defensive re their roles.

Decisions

Zero in on special education problems.

According to Nassau County's District Attorney the teacher has no legal right to search a student but that in all probability no teacher would ever be held libel if he did.

There is an "unwritten law" that special considerations are made in reference to the handicapped offenders; sometimes in a negative rather than a positive manner.

Teachers may be forced into involvement on occasions <u>if</u> a parent is not available.

Parents must give permission for any urine testing done in the schools.

Common sense sets the pace re danger priority and disciplinary action re school incidents. Only parents can press charges through a local precinct.

Teachers cannot be discharged re a corporal punishment case even if it is a district policy.

<u>Issues Mentioned Left Unsolved</u>

The moral and legal responsibility of the teacher.

The handling of school incidents without publicity.

The administration cannot take parental direction re the disposition of a discipline problem with the school.

The humanization of education without including the humanization of the jails and the courts.

The teacher's role re assisting a student who is on trial via the probation office or the defense attorney.

EVALUATION

True - False

Directions: Answer each statement either True or False

1. All drugs are dangerous.
2. Drug users tend to be criminals.
3. Illegal use of drugs tends to shorten the users life.
4. Heroin users are always unproductive members of society.
5. There is a strong evidence that LSD use can lead to chromosomal break-down.
6. An argument in favor of legalizing marijuana is that it is no more dangerous than alcohol.
7. It is easy to identify a hard drug user.
8. There is no difference between use, misuse and abuse of drugs.
9. Use of drugs is illegal.
10. The British plan for handling drug abusers has generally solved the problem in that country.
11. Possession of narcotics is a lesser crime than selling narcotics.
12. Heroin addicts are "hooked" after the first time they use it.
13. Legal use of narcotics is under federal control.
14. Possession of narcotics is a federal offense.
15. Conviction of a crime involving narcotics means that a person has a permanent criminal record.
16. Some children are legally and medically on addictive, dangerous drugs.
17. The school nurse-teacher may administer narcotics with permission from the child's parent or guardian.
18. There is a difference between misuse and abuse of narcotics.
19. Some children may be more prone than others to seek out drugs.
20. Drug abusers generally come from impoverished areas.
21. Hard drug abusers generally come from unhappy home situations.

22. A danger in experimenting with "soft" drugs is that they may lead to "hard" drug use.

23. Unhappiness often seeks an outlet in drugs.

24. An excellent way to prevent drug abuse is to talk about its perils.

25. Like an alcoholic, a drug addict is never really cured.

Results

True - False Test on Drug Abuse

	Pre-Evaluation			Post-Evaluation		
Question	Percent Answered True	Percent Answered False	Percent Answered Undecided	Percent Answered True	Percent Answered False	Percent Answered Undecided
1	26	74	0	28	72	0
2	20	68	12	0	100	0
3	65	35	0	65	35	0
4	20	80	0	14	86	0
5	68	27	5	79	14	7
6	82	15	3	96	4	0
7	29	66	5	31	69	0
8	7	90	3	7	93	0
9	20	75	5	0	100	0
10	6	84	10	14	83	3
11	73	22	5	76	24	0
12	5	92	3	7	93	0
13	64	31	5	72	28	0
14	46	51	3	52	48	0
15	77	20	3	69	31	0
16	95	2	3	93	7	0
17	29	66	5	21	79	0
18	81	15	4	96	4	0
19	95	2	3	100	0	0
20	7	93	0	14	86	0

Results - continued

	Pre-Evaluation			Post-Evaluation		
Question	Percent Answered True	Percent Answered False	Percent Answered Undecided	Percent Answered True	Percent Answered False	Percent Answered Undecided
21	40	55	5	48	52	0
22	80	15	5	72	24	4
23	90	7	3	79	17	4
24	29	71	0	13	83	4
25	42	55	3	41	55	4

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